

Carroll Campion, Ed.S, EMDR, Play Therapy

Licensed Professional Counselor

803.479.2587

Office Policies

This information is designed to orient you to my policies. I hope that reviewing this information will answer questions you may have regarding such policies. If you have a question I will be happy to discuss them with you.

Appointments There is confidential voice mail for messages when I am not available however office appointments may only be made with me. If you cannot keep an appointment, kindly give me **24-hour notice**. **Without** 24-hour notice, there will be an **automatic \$65.00 charge for all missed appointments**. During the first 1-3 sessions you and I will determine if my therapeutic style and our ability to relate is appropriate for us to work together. If either of us decides it is not, then referral to another therapist will be discussed. My practice is a part-time business as listed on both my website and on my brochure. Please check my message weekly for my scheduled private practice days.

Charges **Payment is requested at the end of each session.**

The charge is **\$140.00 per 50-minute session** and **\$180.00 per 90-minute session**. Rarely, there may be an additional fee for other non-routine services; an example of this additional service would include a lengthy phone consultation.

Confidentiality Information about your status as a client or your therapy will not be given to anyone without your written permission. The only exceptions are those which relate to the law such as; a subpoena accompanied with a court ordered mandate, a threat of suicide, homicide, or criminal activity. In other words, harm to self or harm to others.

Also, an indication of abuse of a child must be reported. Therefore with minors the exception to confidentiality includes; harm to self, serious threat of harm to others, and someone harming them. With minors, **regardless of a diagnosis**, if child abuse is reported to me or strongly suspected by me I am a mandated reporter and will contact Child Protective Services.

Confidentiality regarding minors Confidentiality with regard to psychotherapy is a special topic when the client is a minor. As a result, it is my practice to consult with custodial parents or caregivers before therapy begins in order to be certain that an understanding is reached on this delicate issue.

On one hand, parents must understand that a child's therapy is a special time when a trusting relationship develops. In order to respect your child's privacy, **I will not usually share specifics of the sessions.**

However, I may share with you areas of strength, concern, and/or provide general feedback and recommendations, which I feel, are relevant and important for you to know. **You do have my assurance that if there is anything you need to know, I will tell you immediately.**

Emergency In the event of a life-threatening emergency you may call 911 or go to the hospital of your choice.

Consultation It is my practice to consult with other professionals in the context of supervision regarding the progress of client's psychotherapy.

Legal Issues I am not trained in matters that involve the legal system. If you feel that you may need such assistance, I will refer to a specialist. Furthermore, it is **imperative that both custodial parents sign this sheet and consent to the therapy.**

In the unlikely event that I am deposed or otherwise compelled to give testimony, it is understood that my fee will be **\$375.00 per hour plus expenses.** This fee will be paid by the client in advance, and will be assessed regardless of whether or not Counselor is subpoenaed. I have read and understand the above and have kept a copy for my files.

Signature_____

Date_____

Signature_____

Date_____

Virginia provides the consumer the opportunity to file inquiries with its Board of Examiners in Counseling. Board offices may be reached at: Board of Counseling Perimeter Center
9960 Mayland Drive, Suite 300 Richmond, VA 23233 804/367-4610
804/527-4435 (fax) coun@dhp.virginia.gov www.dhp.virginia.gov/counseling

General Information and Consent

For best results and your own welfare, it is important that you understand what it means to be in counseling. Please read the brief description below. If you have any questions or concerns, you are urged to talk about them. If you understand it and you choose to be in counseling as described here, initial each point, sign and date this form. Your signature represents an agreement between us.

Counseling is a special kind of health care service. The goals of counseling are to help you understand yourself and others, to help you solve problems that may be limiting your life satisfaction, and to help cope with the feelings and challenges that you encounter in your daily life: I understand _____yes _____no

The most common form of counseling involves you're talking about your feelings, your problems or concerns, and your experience of yourself and your situation. Other methods used involve using a technique called Eye Movement Desensitization Reprocessing (EMDR), keeping logs, creating a genogram, and the use of Play Therapy for children. These methods may be used within treatment sessions or you may be asked to do them at home.

I understand _____yes _____no

Most people benefit from counseling. The most common benefits include improvements in self-awareness, self-esteem, and self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in counseling. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by counseling is rare, but you should be aware that it could happen. The most common of such damage are poor communication or unethical conduct. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in counseling, you should discuss this with your counselor. If you feel that your therapist has attempted to violate you in any way, financially, physically, sexually, or otherwise-you should so inform the state agency responsible for professional licensing.

I understand _____yes _____no

You always have the right to choose whether or not to continue in counseling. If you feel that you might work better with a different counselor, your present counselor

should be able to offer you information on possible referrals. Local mental health agencies are listed in the phone book and they may also offer helpful information. The most common alternative to counseling are self-help groups, bibliotherapy (therapeutic reading), and different forms of religious counseling. I understand _____ yes _____no

The information communicated in therapy must be kept confidential by your counselor unless you grant permission to release it. State laws dictate the only exceptions to this protection of your privacy.

Confidential information may be released **without** your permission if:

- You threaten yourself or someone else and your threat is believed by law to be serious our counselor is ethically and in some instances legally obligated to take whatever action seems necessary to protect you or others from harm.
- There is suspected child abuse or neglect. Therapists are obligated by law to report this to the necessary state agency. This law also applies if you report that you have reason to believe another person is abusing or neglecting your child.
- You are in a litigation of any kind and inform the court of the services you receive here (**making your mental health an issue before the court**); you may be waiving your right to keep your records confidential.
- You lodge a formal complain against me or make me a party to a legal action.
- You use insurance to reimburse for fees.
- You do not pay your bill and billing information is forwarded to a collection agency.

I understand these limits of confidentiality: _____yes _____no

Your signature below indicates that you have read and understand the above description of counseling. Your signature indicates that you are now consenting to be in counseling with the understanding that you retain the right to review and revise the decision at later points in time.

Signature of Client/Parent/Guardian

Date

Client Information

Date of Service: _____ Insurance Name: _____

Name: _____ Gender: M F

Address: _____ Marital Status: S M D

Zip Code: _____ Cell: _____

Home: _____ Work: _____

Date of Birth: _____ Age: _____

Insurance Membership ID number: _____

E-mail address: _____

Occupation: _____

Employer: _____

Address of Employment: _____

In case of emergency please contact:

Name: _____ Relationship: _____

Cell: _____ Home: _____ Work: _____

Are you presently on any psychiatric medication?

If yes, please name the Psychiatrist or General Practitioner you are seeing and diagnosis received?

If you are here due to a recent car accident please describe.

Are you currently receiving acupuncture, massage, Rolfing, or chiropractic care?

Have you been diagnosed with any autoimmune system disorders such as; Adrenal Fatigue Disorder, Chronic Fatigue Syndrome, Thyroid issues or Epstein-Barr Syndrome?

Describe any sleep disturbance you are currently experiencing?