Phil Prothero, MA, MDIV, Licensed Clinical Mental Health Counselor (068.0076445)
205 Billings Farm Rd., Ste 2D, White River Junction, VT 05001

Redeeming Stories Inc.

# New Client Intake Forms
# for children & teens

Welcome!

I look forward to meeting you in person and getting to know you. Before we meet, it will be helpful for you to complete this paperwork in advance and to bring it with you to the first session. I'll warn you now; it's a lot of paperwork! But please read through all of this information in its entirety. You will learn more about me, how I approach this work and other relevant and important information about our work together. As you read through, please note any questions you have about the information, as we will have time to address those questions when we meet.

If you are not able to print this information in advance, it will be available for you at the office. Feel free to come early and complete the forms in the waiting room. Plan for about 30 minutes to read through and complete all the forms.

This information packet contains the following:

1. **Counseling Agreement and Policies –** pages 2-6 describe specific policies and information that pertains to the professional working relationship between client and counselor, such as fees, confidentiality and limits of confidentiality, etc.
2. **Child Therapy Agreement –** pages 6-7, provides specific information related to working with minors.
3. **Intake Questionnaire –** pages 7-11 provide me with your contact information, family and medical history, and other relevant information.
4. **Acknowledgement Form** – page 12, your signature acknowledges having received a copy of these forms or having been directed where you can get a copy.
5. **Vermont Disclosure Statement** - details my professional qualifications, provides a list of actions that constitute unprofessional conduct according to Vermont statutes, and details the available methods for making a consumer inquiry or filing a complaint with the Vermont Office of Professional Regulations. A printed copy is available in the waiting room, or an electronic copy can be found at: http://www.redeemingstories.com/forms/vt-disclosure.pdf.
6. **Notice of Privacy Practices -** describes how medical information about you may be used and disclosed, and how you can get access to this information. A printed copy is available in the waiting room, or an electronic copy can be found at: http://www.redeemingstories.com/forms/RSI-NPP.pdf.

Please complete this paperwork prior to our initial meeting so that we can spend our time together focusing on the personal concerns that you wish to work on. I look forward to meeting with you.

*Phil Prothero, MA, MDIV, LCMHC, CSAT*

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## Counseling Agreement and Policies

This document describes policies and practices that involve the professional working relationship between client, client's legal guardians, and counselor.

### Counseling philosophy

I approach counseling from the belief that we are all meant to experience lives that are thriving, which includes relationships that provide love, joy, and intimacy. And yet many obstacles may get in the way of experiencing the relationships we desire as lives get disrupted by trauma, abuse, neglect, loss, and other challenges. Coping strategies can appear to help, but they only distract us from the deeper unresolved emotional wounds.

In counseling we will address your present symptoms in the context of your life story. Utilizing experiential, psychodynamic, and cognitive behavioral perspectives, I ally with you to explore the root causes of today's presenting problems. Together, we will explore how your formative experiences and beliefs have shaped your style of relating and beahviors.

As a Certified Sex Addiction Therapist (CSAT), I specialize in working with sexual addiction and sexual compulsive behaviors using a task-centered approach developed by Dr. Patrick Carnes. I have also been trained in Eye Movement Desensitization and Reprocessing (EMDR) and other experiential therapy methods. If applicable to your situation, I may suggest using some of these treatment methods in your therapy and more information about each method will be provided at that time.

At the start of our work, we will identify your specific treatment goals for your therapy and from time to time we will discuss how we are progressing toward those goals. I may encourage you to try other forms of creative expression such as writing, collage, drawing, painting, etc. Certain problems can have a physical component. In such cases, medical consultation will be advised.

I believe in supporting people of all ethnicities, cultures, religions, sexual orientations and physical challenges. I approach counseling with a deep respect of each person's right to choose his or her own spiritual belief system. My theological education has equipped me to work with people of many different faiths with the goal of meeting you where you are spiritually and working within your spiritual framework.

### Risks and benefits of therapy services

While counseling is often very helpful, no guarantees can be made as to its effectiveness or results. For example, if you are seeking marriage counseling, it cannot be guaranteed that your marriage will improve or stay intact. The counseling process can sometimes be disruptive as you deal with different aspects of your life, and it is possible that you might feel worse or symptoms might increase for a time. During our work together you may experience uncomfortable feelings such as sadness, guilt, anger, anxiety or frustration. This can be a normal part of the process and is important to understand before you begin.

The therapeutic work and the decisions you make while receiving counseling may impact how you relate with others in your life. The goal may be to improve the health of relationships, however, sometimes the result of your therapeutic work may result in the ending of relationships. Please ask me for clarification if you ever have any concerns or questions about the therapy process.

### Fees

Counseling fees are as follows:

| | |
|---|---|
| $160 | for 55-minute initial diagnostic evaluation (90791) |
| $75 | for 25-minute individual counseling session (90832) |
| $100 | for 40-minute individual counseling session (90834) |

$150 for 55-minute individual counseling session (90837)

$225 for 85-minute individual counseling session

$225 for 85-minute family or couples counseling session

$60 for 90-minute group therapy session (90853)

Intensive therapy sessions (3, 4, or 8 hours) are also available, inquire for current fees.

Payment is due at the start of each session in the form of cash, check, or debit/credit card. Please write checks payable to Redeeming Stories. I do not carry balances for clients, therefore therapy may terminate if two or more sessions are unpaid.

Extended telephone and email consultations (greater than 5 minutes) and emergency counsel will be billed at the standard hourly session fee per event. Letters and documents requiring more than 15-minutes of preparation, reading or creation are billed at $120 per hour. Court appearances are billed at $250 per hour; travel time is charged at $120 per hour. Billing rates for these services are all prorated at fifteen-minute intervals. The fee for photocopies of medical records is $0.25 per page. Returned checks will result in an extra $45 charge per instance. Every year I review my fees and may find it necessary to increase them. If this occurs during the course of your therapy, you will be given 30-days notice prior to the increase.

I offer a limited number of rate-adjusted counseling hours in my schedule for those that qualify. See the rate adjustment policy form for more information.

If you become involved in legal proceedings that require my mandated participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party in the case. Because of the time involved and the interruption to my clinical work, I charge $250 per hour for preparation and attendance at any legal proceeding that requires my involvement. Please be aware that if you are involved in a lawsuit, entering your mental health records into a court proceeding may not always be in your best interest, I encourage you to discuss these matters with your attorney.

I generally do no write legal letters or court reports. I reserve the right to refuse to write letters on your behalf (unless court mandated) if I feel this would not be in your best interest, if it places me in a dual relationship or if it will compromise our therapeutic relationship.

**Insurance and managed care**

I believe it is important for you to know that when a claim is submitted to your insurance company, you are consenting for your insurance company to collect your protected health information to determine the legitimacy of the claim. In essence, the insurance company has a right to know what they are paying for. They will require a diagnosis, which depending on the diagnosis, may impact your ability to acquire health and life insurance in the future and may adversely affect your ability to acquire a security clearance. Insurance will not cover any intensive therapeutic services (sessions over an hour in duration).

For insurance companies for which I am a contracted provider: If your insurance plan has a mental health benefit then our sessions may be covered under your health insurance plan. You will be responsible for paying your co-pay at time of service for the services covered by your plan. You are responsible for coinsurance payments and all services not covered by your plan (e.g. couples counseling, specialized testing, etc.), which require full payment at time of service. If your insurance company denies payment for services, you will be responsible for paying unpaid fees. In order to use your insurance benefit, you will be required to provide written authorization allowing me to communicate with your insurance company with regard to our work together.

For insurance companies for which I am not a contracted provider: If your insurance plan has an out-of-network mental health benefit then our sessions may be covered under your health insurance plan. I recommend you inquire with your insurance company to learn the specifics of those benefits. I ask that full payment be made at the time of service and at your request; I will provide you with a receipt for services after each session, which you may submit directly to your insurance company for reimbursement. I do not bill

insurance companies that I am not contracted with. You are responsible for obtaining and filling out any appropriate paperwork and submitting it to your insurance company per their protocol. Under no circumstances do I guarantee that your insurance will reimburse therapy services.

**Contacting me**

I hold office hours on Monday through Friday. If you need to contact me between sessions, you may leave me a confidential message at (802) 356-1731 and I will return your call, as I'm able. Please limit your phone contact to appointment scheduling, billing questions and emergencies. I generally limit email contact for scheduling purposes only. If you are trying to reach me on the same day as your scheduled session, please call me rather than email. I make every effort to return calls and emails within 24-hours during my office hours. Calls and emails received on weekends and holidays will be returned the next business day.

Please be aware that email and text messaging are not secure forms of communication. I make attempts at maintaining security on my computer by using encryption software; however email transmission and storage in computer networks other than those owned by Redeeming Stories Inc. involves confidentiality risks beyond my control. To better ensure confidentiality, I recommend not sending sensitive or detailed confidential information via email or other electronic means. Please limit text messages to brief scheduling concerns.

**Scheduling and cancellations**

Standard therapy sessions are 55-minutes in length and begin and end on time. If you are late to your scheduled appointment, the time missed will be lost and will not be made up by extending the session. Longer sessions and intensives are available by request and are limited to schedule availability. Appointments are generally made on a regular, weekly basis. Appointment times are not automatically held open for you from week to week. It is your responsibility to reschedule at the end of each session.

In the event that you are unable to keep your scheduled appointment, you need to provide at least 24 hours advance notice or you will be billed the full session fee. Exceptions may be made for cancellations due to dangerous weather conditions and extreme medical illness. Insurance companies do not reimburse for missed sessions.

**Emergencies**

If you are experiencing a life threatening emergency call 911 for immediate help. If you are in need of crisis counsel and cannot immediately reach me, then call the appropriate 24-hour mental health crisis line for help:

| | | |
|---|---|---|
| Windham & Windsor Counties, VT<br>(800) 622-4235 | Washington County, VT<br>(802) 229-0591 | Orange County, VT<br>(800) 639-6360 |
| National Suicide Prevention Lifeline<br>(800) 273-8255 | | Veterans Crisis Line<br>(800)-273-8255 |

**Length of treatment**

Therapy is a process that is unique to each client and the specific challenges you are experiencing. Some challenges may be effectively worked through in a short period of time (10-20 sessions) while other more complex challenges may take longer. It can be difficult to predict exactly how long therapy will last. The mutually agreed upon treatment goals will serve as a guide for estimating the potential recommended duration of therapy. Addressing relational and emotional symptoms usually takes less time than resolving the underlying core challenges that are creating the unpleasant symptoms. If you have any questions about the length of treatment, please discuss this with me at the start of therapy or at any point during the course of therapy.

**Termination of therapy**

You have the right to choose a counselor who best suits your needs and you have the right to refuse and/or end therapy at any time. You have the right to ask questions about any of the procedures used in the course of your therapy. I have the right to terminate therapy with you under the following conditions:

a) When I believe that therapy is no longer beneficial to you.
b) When I believe that another professional will better serve your needs.
c) If you have not paid for the last two sessions.
d) If you have failed to show up for your last two therapy sessions without providing 24-hour notice.
e) If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified who may be able to help you. If I have a written consent from you, I will provide that professional with information they request about our meetings to date.
f) If you fail to cooperate with the proposed treatment recommendations.
g) If I feel it may be physically unsafe for me to continue working with you.

When our work comes to an end, I ask that we schedule at least one final session in order to review the work completed to date and to discuss further therapeutic recommendations. Occasionally clients may decide to return to therapy in the future to process new challenges. I welcome the opportunity to work with you again, however it will be at my clinical discretion and dependent upon schedule availability. If I am not able to see you immediately, I may either add you to my waiting list or provide you with referrals to other therapists.

**Therapeutic relationship**

Establishing a meaningful therapeutic relationship between client and therapist is essential for effective therapy. Dual relationships between client and therapist can impede the effectiveness of the therapeutic relationship and are discouraged: "Counselor–client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client" (American Counseling Association Code of Ethics, A.5.c).

As a professional, I strive to maintain healthy and appropriate boundaries with clients and former clients at all times. On the rare occasion that I may run into you outside the office, I will do my best to follow your lead regarding if you acknowledge the encounter or not. Whatever you choose, I will be discreet and always maintain your confidentiality.

In an attempt to protect client confidentiality and to limit dual relationships with clients and former clients, I do not accept social or professional networking "friend" requests for any online social or professional networking sites (e.g. Facebook, Linked In, etc.). Please do not try to communicate with me via any interactive social or professional networking site.

**Confidentiality**

Trust is an essential ingredient for effective therapy and confidentiality is a component that assists in the establishing of trust between therapist and client. As a professional, I can assure you that I strive to maintain the strictest ethical standards of confidentiality. It is very important for you to be aware that there are legal exceptions to confidentiality. When it is possible, we will discuss any exceptions to confidentiality as they arise.

The following are situations that may require or allow me to break confidentiality and share information with others:

a) You provide written authorization for me to share confidential information with a specific person or in the case of death or disability, a person's personal representative. You have the right to revoke this authorization by providing a written statement of revocation;
b) When there is reasonable suspicion of abuse or neglect of a child (33 V.S.A. § 4912). The cited statute outlines specific definitions of abuse and neglect that require mandatory reporting under this law, for example: sexual abuse is partly defined as "viewing, possessing, or transmitting child pornography,

with the exclusion of the exchange of images between mutually consenting minors, including the minor whose image is exchanged" and thus would be reportable;

c) Where there is a clear threat to do serious bodily harm to yourself or others (homicidal and/or suicidal, this may include knowledge that a client is HIV positive and is unwilling to inform others with whom he or she is intimately involved);

d) In response to a subpoena issued by the Secretary of State that is associated with a regulatory complaint or disciplinary report;

e) If you are involved in some legal action, it is possible that a court order might require that I provide the court with evidence relating to your sessions. If this should occur, I would prefer to work with you to prevent or limit such action.

f) If you bring charges against the counselor.

Payment by check will potentially permit bank employees to view client names associated and if you have caller identification on your phone, my name may appear on the monitor.

As an ongoing part of my clinical development and to provide you with the best care, I occasionally consult with other counseling professionals. These consultations are conducted in such a way that confidentiality is maintained. I will not share your name or other details that could be used to identify you. If you have questions or concerns about this, please let me know.

Your clinical record will be kept for a period of seven years following your last visit. After seven years your record will be destroyed in a manner that maintains confidentiality.

**Safety policy**

It is important that the counseling office be a safe environment. During the course of therapy, deeply repressed emotions may surface as they are being worked through. To better ensure a safe environment for everyone, all concealed or unconcealed weapons (firearms, knives, etc.) are not allowed in the waiting room or the counseling office. In addition, audio and/or video recording of sessions is prohibited without prior written consent from all concerned parties.

For therapy to be safe and effective, it is essential that clients are not attempting to engage in therapy while under the influence of alcohol, marijuana or other similar legal or illegal substances. If I suspect that you are intoxicated or under the influence of a mind-altering substance, I will immediately end the therapy session and assist you in finding a safe ride home by having you call a friend, family member or taxi. An occurrence of this type will be charged as a missed session at full fee.

## Child Therapy Agreement

Prior to beginning therapy, it is important for you to understand my approach to providing therapy services to minors and to consent to some agreements about your child's confidentiality during the course of his or her therapy. The information herein is in addition to the information contained in the Counseling Agreement and Policies document. Under HIPAA and the ACA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

**Client Confidentiality:**

Therapy is most effective when a trusting relationship exists between the counselor and the client. Privacy is especially important in securing and maintaining that trust. One common goal of therapy is to promote a stronger and better relationship between child and his or her parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater

freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. In Vermont, minors can give consent to receive outpatient mental health counseling, the consent of a parent or legal guardian is not necessary to authorize treatment (18 V.S.A. § 8350). Release of clinical records relating to the minor client is therefore contingent on the minor's consent to release such information.

It is my policy to provide you with general information about therapy status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you details of what your child has disclosed to me without your child's written consent. I will tell you if your child does not attend sessions.

**Disclosure of High Risk Behaviors:**

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. If I ever believe that your child is at serious risk of harming him or herself, another person, or animal, I will inform you.

**Intended Purpose of Therapy:**

As your child's counselor, my role is to be looking out for the best interest of your child (my client). Although I recognize my responsibility to your child may at times require my involvement in conflicts between the caregivers and him or her. I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential and not use it against the child in another context. Neither parent will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent preparing reports, testifying, being in attendance, and any other case-related costs and $120 per hour for travel time.

**Treatment Contract:**

This Child Therapy Agreement in conjunction with the Counseling Agreement and Policies document, Vermont Disclosure Statement, and Notice of Privacy Practices function as your treatment contract. The contract becomes effective once you have read through it, had opportunity to ask me whatever questions you have about the contract and proposed treatment, and when signed by all parties.

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## Intake Questionnaire for Minors

Please complete this questionnaire to the best of your ability. If you need assistance answering some of the questions, please ask your caregivers for help.

**Today's date:** _____

Name: _____ Gender: _____ Age: ____ Date of birth: _____

Home address: _____

City: _____ State: _____ Zip: _____

May I contact you via mail? ☐ Yes ☐ No May I contact you via phone? ☐ Yes ☐ No

Mobile phone: _____ Home phone: _____

Email address: _____ May I contact you via email? ☐ Yes ☐ No

Primary parent/guardian name: _____ Phone number: _____

Secondary parent/guardian name: _____ Phone number: _____

Custody arrangement: _____

**REFERRAL SOUCE**

How did you hear about me? _____

**PURPOSE FOR SEEKING SERVICES**

What are you wanting counseling to help you with: _____

**PRIOR ATTEMPTS TO ADDRESS THESE PROBLEMS**

Please include contact with other professionals, counseling, medications, 12-step, self-help books, types of treatment, etc.

What was helpful in these past attempts and what was not helpful? _____

**MEDICAL HISTORY**

Current & past medical problems and medications: _____

How do you rate your current physical health: ☐ Good ☐ Fair ☐ Poor

**CURRENT STRESSES**

List current factors that are a source of stress for you or your family. They may feel like major or minor stressors.

**CURRENT RELATIONSHIPS**

**Family structure** - list who lives in the current household, their ages, and the quality of the relationships with each other:

**Current intimate/dating relationship** - describe nature of relationship, etc.: _____

**Pets** - describe relationships with pets both past and present: _____

**Spirituality -** is spirituality important to you? Please describe your spiritual beliefs.

**INTERPERSONAL RELATIONSHIPS** - describe how you would characterize your relationship with:

Parents/guardians: _____

Members of the same sex: _____

Members of opposite sex: _____

People in authority: _____

**FRIENDS** – tell me a little about your friends and your relationship with them

**ACTIVITIES/HOBBIES** – tell me about any sports, activities, hobbies, etc. that you enjoy

**SCHOOL & WORK**

Describe your experience of school

Describe your work experience. Do you enjoy work?

**ABILITY TO FUNCTION**

How do you rate your overall ability to function in life right now? *(Circle somewhere on the range of 1-10)*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Unable to function in all areas | Unable to function in most areas | | Serious difficulty functioning | Moderate difficulty functioning | | Mild difficulty functioning | Minimal difficulty functioning | | No difficulty functioning |

In what areas of your life are you experiencing impaired functioning (e.g. school, work, family, friends, etc)?

Have you ever attempted suicide? ☐ Yes ☐ No Have you ever had suicidal thoughts? ☐ Yes ☐ No

Have you had thoughts of harming or killing yourself in the past six months? ☐ Yes ☐ No

**FAMILY HISTORY**

For each member of your family of origin, describe their personality and what your relationship is like with them.

Mother:

Father:

Step-mother:

Step-father:

Siblings:

Other:

What is the nature of your parents' relationship?

Other relevant information about your growing up experience:

Is there anything else that would be helpful for me to know about you?

Check the box for the symptoms that you are experiencing**:** (check all that apply)

| | | |
|---|---|---|
| ❑ Depressed mood | ❑ Tight, tense muscles | ❑ Difficulty concentrating |
| ❑ Cry easily | ❑ Stressed | ❑ Unexplained health problems |
| ❑ Feeling hopeless | ❑ Emotionally overwhelmed | ❑ Headaches/migraine |
| ❑ Feel worthless | ❑ Bad dreams/nightmares | ❑ Memory problems |
| ❑ Low self-esteem | ❑ Suicidal thoughts | ❑ Caretaking others, neglecting self |
| ❑ Anxious | ❑ Changes in appetite | ❑ People pleasing |
| ❑ Irritable/angry | ❑ Sleep too much/too little | ❑ Inability to stop certain behaviors |
| ❑ Tired | ❑ Difficulty relaxing | ❑ Concern about my alcohol use |
| ❑ Fearful/scared | ❑ Difficulty feeling emotions | ❑ Concern about my drug use |
| ❑ Worrying | ❑ Difficulty expressing emotion | ❑ Concern about my sex behaviors |
| ❑ Racing thoughts | ❑ Feel bad after sexual behavior | ❑ Concern about other behaviors |
| ❑ Ruminating thoughts | ❑ Sexually anorexic (no libido) | ❑ Other: _____ |
| ❑ Unwanted thoughts | ❑ Desire for perfection | |

Check the box of descriptors that describe how you view yourself: (check all that apply)

| | | | | |
|---|---|---|---|---|
| ❑ Intelligent | ❑ Worthwhile | ❑ Naïve | ❑ Addict | ❑ Unlovable |
| ❑ Ambitious | ❑ Strong | ❑ Numb | ❑ Full of regrets | ❑ Indecisive |
| ❑ Trustworthy | ❑ Courageous | ❑ Conflicted | ❑ Aggressive | ❑ Liar |
| ❑ Lovable | ❑ Playful | ❑ Scared | ❑ Worthless | ❑ Lazy |
| ❑ Hard working | ❑ Adventurous | ❑ Melancholy | ❑ Unattractive | ❑ Defective |
| ❑ Confident | ❑ Curious | ❑ Anxious | ❑ Inadequate | ❑ _____ |
| ❑ Sensitive | ❑ Creative | ❑ Not fully present | ❑ Stupid | ❑ _____ |
| ❑ Compassionate | ❑ Beautiful | ❑ Angry | ❑ Incompetent | ❑ _____ |
| ❑ Honest | ❑ Confused | ❑ Codependent | ❑ Weak | |

Check the box of the life events that you have experienced: (check all that apply)

| | | |
|---|---|---|
| ❑ Parents divorced | ❑ School/academic problems | ❑ Death of beloved pet |
| ❑ Poverty | ❑ Legal problems | ❑ Recent job loss |
| ❑ Bullying | ❑ Incarceration (jail) | ❑ Unwanted pregnancy |
| ❑ Physical abuse | ❑ Suicide of friend/family | ❑ _____ |
| ❑ Sexual abuse | ❑ Death of a friend | ❑ _____ |
| ❑ Emotional/verbal abuse | ❑ Death of family member | |

Circle the frequency of how often you use the substance or participate in these behaviors:

| | |
|---|---|
| Alcohol (beer, liquor, wine, etc.) | never-occasionally-weekly-daily |
| Marijuana (hashish, etc.) | never-occasionally-weekly-daily |
| Opioids (oxycodone, fentanyl, codeine, heroin, etc.) | never-occasionally-weekly-daily |
| Hallucinogens (LSD, mushrooms, PCP, ketamine, etc.) | never-occasionally-weekly-daily |
| Stimulants (cocaine, meth, MDMA, amphetamine, synthetics, etc.) | never-occasionally-weekly-daily |
| Nicotine (cigarettes, vaping, chew, dip, cigars, etc.) | never-occasionally-weekly-daily |
| View sexually explicit media (images, movies, stories, chat, etc.) | never-occasionally-weekly-daily |
| Sexual behaviors (escorts, prostitutes, sexual massage, hookup apps, etc.) | never-occasionally-weekly-daily |
| Gambling (casinos, online gambling, etc.) | never-occasionally-weekly-daily |
| Problematic eating behaviors (binge, purge, anorexia, etc.) | never-occasionally-weekly-daily |
| Video game use (gaming console, smartphone, computer, etc.) | never-occasionally-weekly-daily |
| Social media use (Instagram, Facebook, Twitter, Snapchat, etc.) | never-monthly-weekly-daily-hourly |

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## ACKNOWLEDGEMENT OF RECEIPT OF DISCLOSURE INFORMATION

This disclosure of information packet contains the following:

1. **Counseling Agreement and Policies** - describes specific policies and practices that involve the therapeutic working relationship between client and counselor, such as fees, confidentiality and limits of confidentiality, etc.
2. **Child Therapy Agreement –** provides specific information related to working with minors.
3. **Vermont Disclosure Statement** - details the professional qualifications for your counselor, Phil Prothero, LCMHC, provides a list of actions that constitute unprofessional conduct according to Vermont statutes, and details the available methods for making a consumer inquiry or filing a complaint with the Vermont Office of Professional Regulations. A printed copy is available in the waiting room, or an electronic copy can be found at: http://www.redeemingstories.com/forms/vt-disclosure.pdf.
4. **Notice of Privacy Practices -** describes how medical information about you may be used and disclosed, and how you can get access to this information. A printed copy is available in the waiting room, or an electronic copy can be found at: http://www.redeemingstories.com/forms/RSI-NPP.pdf.

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My signature below acknowledges:

- I have been given a copy of and/or directed to the location where I can access the Vermont Disclosure Statement detailing the professional qualifications of my counselor, Phil Prothero, LCMHC, a listing of actions that constitutes unprofessional conduct according to Vermont statues, and the methods for making a consumer inquiry or filing a complaint with the Vermont Office of Regulations.
- I have received a copy of and read the "Counseling Agreement and Policies".
- I have read through the Child Therapy Agreement and agree to abide by the terms of the agreement
- I have been given a copy of and/or directed to the location where I can access the "Notice of Privacy Practices" from Redeeming Stories Inc.
- I have been given opportunity to discuss my questions regarding all of this information with my counselor.

| | | |
|---|---|---|
| Minor client signature | Date | Minor client printed name |
| Parent/Custodian 1 signature | Date | Parent/Custodian 1 printed name |
| Parent/Custodian 2 signature | Date | Parent/Custodian 2 printed name |
| Counselor signature | Date | Phil Prothero, LCMHC<br>Counselor printed name |