Directive Counseling
June Lin-Lee, MS, Med., LAMFT
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P) 480-269-7730

Child/Adolescent Intake

Child Name: _____ DOB: _____

Address: _____City _____ Zip _____

Sex ☐ Male ☐ Female Age: _____

School attending _____ Grade (current or entering) _____

Is patient adopted? Yes No If yes, at what age? _____

Race/Ethnicity
☐ Caucasian ☐ Native American ☐ Multiracial _____
☐ African American ☐ Asia ☐ Latin or Spanish ☐ Other _____

Biological Parents (or Guardian information):

Are Biological parents divorced or separated? Yes No If yes, for how long _____

If yes, do parents share custody? Yes No ** Court documentation must be provided

Parent: _____ Relationship _____

Phone: _____ okay to leave msg? ☐ Yes ☐ No

Occupation: _____

Email: _____ okay to use email? ☐ Yes ☐ No

Co-Parent:_____ Relationship _____

Phone: _____ okay to leave msg? ☐ Yes ☐ No

Occupation: _____

Email: _____ okay to use email? ☐ Yes ☐ No

Siblings (include biological, adopted, foster, step, etc.)

Name		Sex	Age	Type (bio,step,etc.)	Custody?
_____	____	____	_____		☐ Yes ☐ No
_____	____	____	_____		☐ Yes ☐ No
_____	____	____	_____		☐ Yes ☐ No

Anyone else living in your household other than parents or siblings? Yes No

***If yes, please give name(s) and relationship:

_____

Person to contact in case of emergency Phone Number

COUNSELING HISTORY OF CHILD/ADOLESCENT

Prior counseling experience:

From: _____ To: _____ With Whom? _____

How were you referred to me? _____

Is there any history of mental health issues in family? (if yes, please describe) _____

_____

Basic Health ☐ Good ☐ Fair ☐ Poor Date of last exam? _____
Physician's Name: _____ Phone: _____

Is child/adolescent taking any prescription medication at this time? ☐ Yes ☐ No

If yes, what? _____

Is child/adolescent taking any over the counter medication at this time? ☐ Yes ☐ No

If yes, what? _____

Current reason for seeking counseling

Are there any physical, emotional, or mental issues now or in the past that I need to be aware of ? Yes / No

If yes, what? _____

Has child/adolescent ever been hospitalized? Yes / No

If yes, for what and when _____

Briefly describe the problem for which you wish your child/adolescent to have counseling:

_____

_____

_____

The thing that concerns me most right now is: _____

_____

_____

_____

Counseling would be successful if: _____

_____

I understand that suicidal threats, homicidal threats or child abuse will be reported.
I understand that the parent must facilitate the ability for child/adolescent to trust the therapist and will respectconfidentiality when appropriate.

Parent (s) Signature : _____ _____

Print names : _____ _____

Adolescent Signature: _____

Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- ☐ Depression or Anxiety
- ☐ Alcohol or other drug abuse
- ☐ Communication Difficulties
- ☐ Harm to self or others
- ☐ Abuse (physical/verbal/sexual)
- ☐ Sexual Orientation Questions
- ☐ Child Adjustment/Parent Conflict
- ☐ Divorce
- ☐ Adoption
- ☐ _____
- ☐ Difficulty with loss or death
- ☐ School adjustment problems
- ☐ School learning difficulties
- ☐ Low self Esteem/social withdraw
- ☐ General Defiance
- ☐ Staying Focused/Task Completion
- ☐ Eating Disorder/Obesity
- ☐ Individual Counseling
- ☐ Family Counseling
- ☐ _____

What event happened which made you think "I am (we are) calling a therapist?" _____

_____

_____

Modality – who would you like to see participate in counseling?:

_____

_____

_____

What behaviors would you like to change? _____

_____

_____

Patient's strengths and interests: _____

_____

_____

Specific Goals identified (can be completed with therapist) Plan Review Date: 6 months from intake

_____

_____

_____

Patient Signature _____ Date _____

Parent Signature_____ Date _____

Signature_____ Date _____
June Lin-Lee, M.Ed., M.S., LAMFT 10534

Informed Consent for Assessment and Treatment

We want to welcome you to our practice at Directive Counseling. We are pleased you have chosen our services. In order to assist you in understanding the responsibilities and expectations involved in the counseling relationship we ask that you read and sign the following informed consent. At the close of your initial session, if you choose to continue counseling, you may request a copy for your personal reference.

Your sessions will be held with a Licensed Associate Marriage and Family Therapist in the State of Arizona. This means that your therapist has earned her master's degree and state exams have been passed. June is undergoing the full professional licensure process and is under clinical supervision. We reserve the right to refer a client to another therapist or an appropriate resource at any time if their needs in therapy are not a good match for our skills or experience. In order to promote progress, June will ask you to complete some interventions—in session and sometimes at home—throughout the duration of your therapy. These interventions will be relevant to your therapy goals, and your completion of the interventions will be essential to your progress.

One of the distinctive aspects of June's practice is her commitment to provide quality professional Christian counseling *to those who desire such an emphasis*. It is not essential that her clients share her beliefs, but you have a right to know that these are her value assumptions are rooted in her faith in Christ. ***June is committed to providing a safe environment in which you can experience the freedom to explore your own beliefs and make your own choices regarding life and your relationships***. Her desire is to support and not hinder this process. The emphasis on quality counseling is based on professional training, and is continually being expanded through ongoing involvement in the continuing education process through seminars, research, supervisions, networking with other professionals, and personal reading and study. The Christian emphasis is based upon reliance on the Bible as the ultimate source of truth, and in the supernatural power of Jesus Christ and the Holy Spirit to transform lives. This does not imply that everything done in the counseling session will be of a "spiritual" nature, rather, this may be the framework upon which we will implement various techniques and tools as they appear to be most beneficial for the specific individual if desired.

June has an eclectic orientation to her practice. This means she does not practice with one orientation, but rather has training and experience in several orientations and incorporates them into her practice. Some of the orientations are Behavioral Theory including Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT), Family Systems Theory, Solution Focused Brief Therapy, and Gottman's Couple's Theory. This is to get you the benefit of an experienced professional in my committed service to you.

Financial. Payment is expected at the time the service is rendered. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. Currently, the standard fee for a 50 minute counseling session is $125.00 In addition to the basic session and assessment fees, there may be other fees for additional services such as psychometric testing, telephone counseling, books and materials, etc. There will be a $25.00 fee for checks that are returned as non-sufficient funds or non-payable. We reserve the right to change our fees with 30 days notice. You have the right to be informed of all fees that you are required to pay and our refund and collection policies. Please discuss these with us if you have a concern. Consultation, supervision and seminar fees vary and are contracted on a case-by-case basis. CC does utilize The Bureau of Medical Economics for collection services in most cases when balances are not paid within 90 days of the balance starting to accrue.

Insurance. *June is NOT currently a credentialed provider with any insurance companies. This means, June does not currently bill any insurance companies.* If you are using an insurance program and you would like to submit for out-of-network benefits, we will supply you with a superbill that you can turn into your insurance company. They may then reimburse you directly. We do not provide correspondence with any insurance companies due to our out-of-network status. In all cases, payment for services are due at the time of service and is the responsibility of the client.

Availability of services. Our practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to the local hotlines (Empact – 480-784-1500, Banner Help line - 602-254-4357, ValueOptions – 602-222-9444). June's cell phone number is 480-269-7730. An immediate response is not guaranteed. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation.

Appointments. Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. June reserves 45-50 minutes for each appointment with a client. Appointments canceled at the last minute are very detrimental to June's practice. Therefore, we ask that you notify her a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. ***You will be financially responsible for appointments you fail to cancel in accordance with this policy.*** If you no show, no call your first intake appointment and still would like counseling, you may be required to pre-pay your appointment before re-scheduling the appointment. Appointment availability varies with the client load at the time. High demand appointment times are likely to be sporadic in their availability. We reserve the right to limit our commitments of high demand appointment times to any particular client in order to meet the needs of all our clients and balance our workloads. ***Our office is not able to do reminder calls. Therefore, please make a note of the date and time of your next appointment whether it is made over the phone or in person.***

Privacy, confidentiality, and records. Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statues. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved. We also participate in a process where selected cases are discussed with other professional colleagues to facilitate June's continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods. In addition, it is a requirement by the Arizona Board of

Behavioral Health Examiners that June participates in regularly scheduled supervision as an LAMFT to ensure best practice. If you have any questions or concerns you can contact June's supervisor Leonard V. Nasca, LCSW. There are also numerous other circumstances when information may be released including when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against us, to comply with worker compensation laws, to comply with the USA Patriot Act and to comply with other federal, state or local laws. The rules and laws regarding confidentiality, privacy, and records are complex. ***Request for Records - Our agency requires a signed written notice before copies of records or in order for records to be sent to another party. Our agency has up to 10 business days to fulfill the request. The fee for copying a chart is $20 for the first twenty pages and .25 for each additional page.***

Purpose, limitations, and risks of treatment. Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is a chance that you could have an increase of symptoms, before you start feeling better, because of the nature of bringing them into direct light. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. Of course, the potential for a divorce is always a risk in marital counseling.

Also, if you are married and primarily seeking marital counseling, a single chart will be created in both spouses' names. Please be aware that if records from a joint marital chart are requested by any party or entity in the future, the signatures of both spouses must be obtained in order to voluntarily release any information. If you are a married couple seeking marital counseling and you would prefer separate charts in each of your names, please specifically request this and every effort will be made to accommodate your request.

Important to note and agree upon for marital counseling/co-therapy or in multi-client cases: By signing this Agreement, you are agreeing that any information you disclose is acceptable to share with the other spouse or other client(s) in the treatment process with you. In other words, in marital counseling or co-therapy, secretive information will not be confidentially held between one of the clients and June and subsequently withheld from the other spouse; June will not agree to hold any secretive information between the spouses. Unless June believes that there is imminent danger to one of the spouses if the disclosed information is shared, all information shared by each spouse is free to be shared with the other spouse, even if that particular information was originally shared in an individual session or by phone or email. If you have any questions regarding this ethical stance and preference, please ask June before you sign this agreement.

Treatment process and rights. Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic

review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal. The recording of any counseling session is strictly prohibited without the written consent of the counselor and client. This includes any type of audio or video devices.

Our relationship. The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is usually inappropriate for a client and a counselor to spend time together socially. The purpose of these boundaries is to ensure that you and your therapist are clear in our roles for your treatment and that your confidentiality is maintained. If our paths cross out in the community, you need to know that your therapist will not acknowledge you without you initiating the interaction first. June will not respond to friend requests on Facebook and other social media/networking sites during the course of our professional relationship so as to maintain a professional relationship. If phone conversation exceeds 8 minutes, you will be billed.

If you need to confirm an appointment, text June 480-269-7730 and you will be reminded of your appointment time. I do email (junelinlee7mft@gmail.com) when necessary and please know we do not have an encrypted server.

If your therapist ever gets seriously injured, ill, needs to take an extended leave of absence or suffers from an accident and is unable to meet with you, a representative from Directive Counseling, will become June's conservator of her client records. She/he would contact you to inform you and discuss the way forward.

If there is ever time you feel like you have been treated unfairly or disrespectfully, please talk directly to June. It is never our intention to cause this to happen to our clients, but sometimes misunderstandings can inadvertently result in hurt feelings. We want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

Consent for evaluation and treatment. Consent is hereby given for evaluation and treatment under the terms described in this consent document. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature:_____ Date: _____

Signature:_____ Date: _____

Signature:_____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor : _____ DOB _____ Relationship: _____

Therapist Signature: _____ Date: _____

Informed Consent for Telehealth
This consent is in addition to the standard consent for therapy and not intended to be exhaustive.

Please read the following telehealth therapy consent and sign below. If you have any questions, please let your therapist know, so we can get them answered and an informed decision can be made.

1. I understand that I am about to engage in a telehealth therapy session with my provider at Freedom Family Counseling.

2. I understand that the using technology will not be the same as an in-person session with a provider due to the fact that I will not be in the same room as my provider. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.

3. I understand the potential risks to this technology, include interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telehealth therapy session if it is felt that the technological connections are not adequate for the situation.

4. My provider and I mutually agree to inform each other and obtain the necessary consent if another person is present during the session. Taping sessions will only be allowed under the guidelines in our practices main Consent for Treatment regarding taping sessions.

5. I understand that there are alternatives to telehealth therapy available, including the option of finding another provider to see in-person if available in my area.

6. I understand that I can direct questions about this telehealth therapy session at any time to my provider.

7. I understand that this consent will last for the duration of the relationship with my provider, including any additional telehealth therapy sessions I may have; I can withdraw my consent for a telehealth therapy session at any time.

8. I understand that same confidentiality protections, limits to confidentiality, and rules around my records apply to a telehealth therapy session as they would to an in-person session.

9. I agree to work with my provider to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions and what will happen should we get disconnected before the typical end of the session.

10. I understand that my provider may decide to terminate telehealth therapy services, if they deem it inappropriate for me to continue therapy through this means.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I agree to participate in a telehealth therapy session(s) with this practice.

Signature:_____ Date: _____

Signature:_____ Date: _____

Signature:_____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor : _____ DOB _____ Relationship: _____

Therapist Signature: _____ Date: _____

PAYMENT AGREEMENT

If using HSA, FSA, or Credit Card for payment

For services with June Lin-Lee, MA-Ed, M.S., LMFT

Name on Credit Card_____

Card Number_____ 3 digit security code ____

Expiration Date_____ Billing Zip Code of Credit Card _____

Email for send of Receipt _____

I authorize: To keep on file for on going copay or session fee payment

I agree to allow June Lin-Lee, LAMFT to charge the above credit card to be used to settle fees for therapeutic services.

For office use only - verification that client has read and understands informed consent document

Authorized Representative: _____ Date: _____

Therapist Name: _____