Dear Client,

We are so happy that you have choose The Mahogany Projek for your counseling services. We are also so proud of your for taking a brave and positive step in your personal growth by seeking counseling. We want to tell you about our practice and welcome you into our care.

The Mahogany Projek, LLC is open to you regardless of where you live; we have an office in Hampton, VA but we offer "Come-to-you" services where we travel to you. We opened in 2018 to provide innovative and creative options for therapeutic services to individuals in the community.

We provide individual, couple, family, group and relationship (mom/daughter, friends, father/son, etc.) counseling and therapeutic services. We address topics that include but are not limited to interpersonal patterns/issues, ineffective coping skills, substance abuse, psychiatric concerns, relational distress, depression, anxiety, etc.

An awesome part of our practice is our desire to train and educate up and coming counseling professionals by having interns and providing supervision to residents in counseling.

We invite you to learn more about the practice. Feel free to ask about the many services available for you and your family. Welcome to the The Mahogany Projek – we hope it will be a positive experience for you.

Warmly,

Sharde' O'Rourke, LPC, LSATP, CCTP
Owner

4410 East Claiborne Square Suite 334
Hampton, VA 23666
www.themahoganyprojek.com

Client ID #:

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any questions you would rather not answer or would prefer to discuss with your therapist/counselor. Information you provide here is held to the same standards of confidentiality as our therapy.

DEMOGRAPHIC INFORMATION:		
Name:		Date:
Birthdate:	Age:	Phone #:
Social Security #:		
Address:		
City:	State:	Zipcode:
Cell #:	Work#:	Other #:
On what phone number can we leave a **confidential** message? ☐ yes ☐ no		
If so, which #? ☐ Cell ☐ Work ☐ Other		
EMPLOYER & STATUS:		
Company:		
Address:		
City:	State:	Zipcode:
☐ I am self-employed	☐ I am unemployed	☐ I am retired
I am: ☐ Single ☐ Married ☐ Divorced ☐ Partnered		
How many people live in your household?		
EMERGENCY CONTACT INFO:		
Emergency Contact Name:		Phone #:
Relationship to you/client?		
INSURANCE INFO:		
Will you be using insurance? ☐ yes ☐ no		
If you will be using insurance, please complete the insurance info section.		
Primary insurance carrier:		
Member ID #:		
Group ID #:		
Effective Date:		
Phone #:		
Secondary insurance carrier:		

Client ID #:

Member ID #:
Group ID #:
Effective Date:
Phone #:
ADDITIONAL INFO:
Counseling you are seeking: ☐ **Individual** ☐ **Couple** ☐ **Family** ☐ **Group** ☐ **Friend/Relationship**
Are you interested in group counseling? ☐ yes ☐ no
Have you obtained services with The Mahogany Projek, LLC before? ☐ yes ☐ no
Are you required by a court of law to receive counseling as a part of a legal proceeding? ☐ yes ☐ no

TREATMENT HISTORY:

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐ yes ☐ no

Have you had previous psychotherapy, psychiatric services or counseling?
☐ no
☐ yes, with (previous therapist's name) ______________________________

Have you ever been diagnosed with a mental health condition? ☐ yes ☐ no

If yes, what was the diagnosis? ______________________________

Are you currently taking prescribed psychiatric or medical medication (antidepressants, etc.)?
☐ yes ☐ no

If yes, please list:

Medication Name	Dosage	Routine	Prescriber

Client ID #:

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician/doctor? ☐ yes ☐ no

If yes, who is it? ____
Are you currently seeing more than one medical specialist? ☐ yes ☐ no

If yes, please list: ____

When was your last physical? ______________________________________

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: ________________________________

____

Are you currently on medication to manage a physical health concern? ☐ yes ☐ no
If yes, please include in the medication are above.

Are you having any problems with your sleep habits? ☐ yes ☐ no

If yes, check where applicable:
☐ Sleeping too little. ☐ Sleeping too much ☐ Poor quality sleep
☐ Disturbing dreams ☐ Other: ____

How many times per week do you exercise? ____________ Days

Client ID #:

How long each time? ____________________ Minutes/Hours

Are you having any difficulty with appetite or eating habits? ☐ yes ☐ no

If yes, check where applicable:

☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting

Have you experienced significant weight change in the last 3 months? ☐ yes ☐ no

Do you regularly drink alcohol? ☐ yes ☐ no

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

____

How often do you engage recreational drug use to include over use of prescriptions, marijuana, cocaine, heroin, etc.?

☐ daily ☐ weekly ☐ monthly ☐ rarely ☐ use to ☐ as a child/teen ☐never

Do you smoke cigarettes or use other tobacco products? ☐ yes ☐ no

Have you had suicidal thoughts in the last 30 days?

☐ frequently ☐ sometimes ☐ rarely ☐ never

Have you had them in the past?

☐ frequently ☐ sometimes ☐ rarely ☐ never

If yes, do you have a plan? ☐ yes ☐ no

Have you attempted? ☐ yes ☐

Were you ever hospitalized for such behavior? ☐ yes ☐ no

Are you currently in a romantic relationship? ☐ yes ☐ no

If yes, how long have you been in this relationship? ______________________

Client ID #:

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? ________

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: ____

____

Have you ever experienced any of the following?

Educate. Explore. Acknowledge. Love

Client ID #:

SYMPTOM ASSESSMENT:

I AM EXPERIENCING...	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING ...	Never	Seldom	Often	Always	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

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Client ID #:

I Notice...	Never	Seldom	Often	Always	For how long?
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE ...	Never	Seldom	Often	Always	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					

I HAVE ...	Never	Seldom	Often	Always	For how long?
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
Risk Taking behaviors					

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Client ID #:

I USE THE FOLLOWING ...	Never	Seldom	Often	Always	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					

MY EATING INVOLVES ...	Never	Seldom	Often	Always	For how long?
A lot of weight loss or gain					
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					

I HAVE ...	Never	Seldom	Often	Always	For how long?
Questions about my sexual orientation					
Concern about my sexual function					
Discomfort engaging in sexual activity					

EMPLOYMENT & SELF-CARE ...	Never	Seldom	Often	Always	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					

Client ID #:

I have problems accessing healthcare					

OCCUPATIONAL INFORMATION:

Are you currently employed? ☐ yes ☐ no

If yes, who is your currently employer/position? ___________________________

If yes, are you happy with your current position? ☐ yes ☐ no

Please list any work-related stressors, if any ___________________________

____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ☐ yes ☐ no

If yes, what is your faith? ______________________

If no, do you consider yourself to be spiritual? ☐ yes ☐ no

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	☐ yes ☐ no	Family member
Depression	☐ yes ☐ no	
Bipolar disorder	☐ yes ☐ no	
Anxiety disorder	☐ yes ☐ no	
Panic attacks	☐ yes ☐ no	
Schizophrenia	☐ yes ☐ no	

Client ID #:

Alcohol/substance abuse	☐ yes ☐ no	
Eating disorders	☐ yes ☐ no	
Learning disabilities	☐ yes ☐ no	
Trauma history	☐ yes ☐ no	
Suicide attempts	☐ yes ☐ no	
Chronic illness	☐ yes ☐ no	

OTHER INFORMATION

What do you consider to be your strengths? ________________________________

____

____

What do you like most about yourself? ________________________________

____

What are effective coping strategies that you have learned and practice?

____

____

____

What are your goals for therapy?

____

____

____

Client ID #: ______________________________

______________________ ______________________ ______________________

Signature of Client | Printed Name of Client | Date

Educate. Explore. Acknowledge. Love

Client #:

Consent for Treatment

Please read carefully. *Psychotherapy/Counseling is a working cooperative relationship between you and your counselor. Each member of this cooperative relationship has certain responsibilities. Your counselor will contribute their knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.*

I. Client/Therapist Relationship

You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts over $5.00 (both purchased and homemade) are not appropriate, nor is any sort of trade of service for service.

II. Fees and Appointments

1. The fees range from $75.00 to $195 per 50-minute session for ongoing individual, couples & family counseling and dependent on the therapist/counselor's experience.
2. Weekend Hours: $150.00 per 50-minute hour
3. Intake appointments are 90-minutes and range from $150 -$195
4. All of our staff continue to receive continuing education on an ongoing basis, as well as weekly supervision.
5. Co-parenting classes (4-6 weeks) are $250.00 per person (not covered by insurance).
6. $50.00 -Emergency Phone therapy 30 minutes (for on-going clients only)
7. $100.00- For any letter required to be written on your behalf. Insurance will not cover this service.
8. All fees are expected to be paid in full prior to each session. The Mahogany Projek accepts cash, credit cards (MasterCard, Visa, Discover, American Express) personal checks.

Client #:

9. There is a $35.00 service fee for any returned checks. If determined that therapy will continue, you must your overdue balance prior to attending your next appointment.
10. Our paperwork for your first appointment is available online on our website. Using this system save you time and ensures we are ready to proceed with your first appointment in a timely manner.
11. **Insurance:**
    a. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.
    b. We still bill *some* insurances, but there are several reasons that we limit that:
        I. One reason is that to bill insurance we **must** assign a mental health diagnosis, and many times clients simply want to come in to work things out in their lives, and don't want or even **fit** a diagnosis. They may also not want to have that information released to their insurance company. Many of our clients want to have complete confidentiality and do not elect to use their insurance.
        II. You will want to ask your insurance company about deductible requirements, authorization requirements, percentage of co-payment, number of sessions per year and "In-Network" vs. "Out-of-Network" benefits. Contracting with insurance companies is the decision of each individual therapist. The Mahogany Projek, LLC will be glad to assist you by providing and filing the necessary information for insurance reimbursement.
        III. You will be responsible for any charges not covered by Insurance due to lack of precertification/authorization for an out-of-network provider or service that is not covered.
        IV. We do not accept many insurance carriers because there are so many different mental health subcontracting companies that we cannot guarantee that we will be paid;

Client #:

that leaves our clients responsible for payment and we do not think a surprise bill is fair or just. It also leaves our clients unexpectedly owing us, and we do not like clients to feel they were misled.

V. We accept payment at the time of your appointment, and we will provide a statement for you to bill your insurance or medical savings or flexible spending account for insurances and payments that we do not accept. We accept checks, credit cards, and cash at the time of appointment.

VI. We do ask for a credit card to schedule an appointment to hold it for you. We do not charge it unless there is a no-call, no-show. That ensures your therapist/counselor is available for you, and that we can set a schedule that works for you.

12. Appointment Cancellation: We adhere to a ***24-hour*** advance notice cancellation policy. You are expected to pay $60 for your session if you do not cancel within ***24 hours.*** Insurance does not cover this cost.

Currently we accept the following insurance:

Please inquire about the insurances we currently accept. ***Please note: as explained above, you are still 100% responsible for your fees if your insurance company denies your claim. Please check your insurance coverage before your session.***

1. Prior to the session we ask that you provide your insurance information to confirm your coverage. You can take a photo of your insurance card (front and back) and email it to info@themahoganyprojek.com. We prefer that you provide this information a week in advance.

   Finally, you need to be aware that most insurance companies do not cover counseling for personal growth issues including relationships and or couples' therapy, parenting, co-parenting, or as a school requirement.

Client #:

Come-to-you Services:

*We offer premium services that may be a good fit you, if you are an office strapped executive and you would like us to come to your place of business, or maybe you are a working mom with a hectic work schedule that needs weekend hours these services are just right for you. For an additional fee we can make your experience even more convenient for you. Most Insurance plans will **not** cover these services.*

- Off-site Therapy: $220.00 per 50-minute hour plus travel time. (Site to Site)
- Other options are available just speak to your therapist/counselor.

III. Confidentiality

1. Communication between you and your counselor is confidential. This means that your counselor will not discuss your case orally or in writing without your expressed written permission (please see the following section on "Training and Supervision").
2. Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:
    a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
    b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
    c. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
    d. If you introduce your emotional condition into a legal proceeding.
    e. If there is a court order for release of your records.
3. If my therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby

Client #:

specifically give consent to my therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name: ____

Telephone Number: _____________________________________

III. Training and Clinical Supervision

1. The Mahogany Projek, LLC (TMP) provides training to counseling/psychology interns, QMHP's and residents. All counselors/interns at TMP are under the supervision of licensed mental health professionals.
2. In order to ensure that counselors receive the best possible training, and that clients are well served, sessions may be attended by an intern or resident only if the client agrees.

IV. Counselor/Therapists Availability and After-Hours Emergencies

Counselors/Therapists check for voice mail messages during normal business hours. Messages left outside of normal TMP hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department, emergency services (757) 788 -0011 or call 9-1-1. TMP does not provide after hour services. When your therapist is out of town, you will be advised and given the name of an on-call therapist.

V. Child Care Release

Client #:

TMP does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 12 may not be left without supervision in the waiting room.

VI. Risk and Benefits

Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process; however, some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

VII. Counseling

We provide both short- and long-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your therapist will determine your concerns, and if both agree that we can meet your therapeutic needs, a plan of treatment will be developed. Should you choose not to follow the plan of treatment provided to you by your therapist, services to you may be terminated.

The goal of The Mahogany Projek, LLC is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current therapist are not a good fit, please discuss this matter with your therapist/counselor to determine if transferring to a more suitable therapist/counselor is right for you; however, if we are unable to accommodate you we will refer you to an outside provider. If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Client #:

Wellness is more than the absence of disease; it is a state being. It goes beyond the curing of illness to achieving health. Through the ongoing incorporation of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an cohesive solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

VIII. Your rights

It is the policy of The Mahogany Projek, LLC that all individuals who are seeking and/or receiving services from any of our services will be provided with effective, efficient services. These services will be directed toward health and habilitation. As an individual receiving services at our offices, you have the following rights:

1. To be treated with consideration and respect for human dignity;
2. To receive quality treatment regardless of race, religion, sex, age, ethnic background, mental and/or
3. physically disabling condition;
4. To be provided confidentiality and protection from any unwarranted disclosure regarding your treatment;
5. To be involved in planning your treatment and to be informed about your treatment process;
6. To be involved in your discharge and aftercare planning;
7. To refuse treatment to the extent permitted by law and to be informed of the possible consequences of your actions;
8. To expect continuity of care from one service to another, should you need another service;
9. To examine and receive an explanation about the bill for your services;
10. To schedule an appointment with your counselor to review your record and receive any needed explanation about the contents.

IX. Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with

Client #:

the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

TMP reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by TMP of your therapeutic needs, TMP's ability to address those needs, or other circumstances that led TMP to conclude in its sole and absolute discretion that your counseling needs would be better served at an another counseling facility. Under such circumstances, TMP will provide recommendations/referrals to an appropriate counselor(s) or counseling agency.

X. Safety Policy

The use/and/or possession of drugs, alcohol, firearms and weapons of any kind are strictly prohibited on any location where therapy sessions are being conducted or on the property of/through The Mahogany Projek, LLC. It is also expected that staff and clients alike will be treated with respect to include the client being transferred, discharged and or the police called for any of the following behavior:

1. Verbally or Physically aggressive behavior
2. Verbally aggressive or vulgar language
3. Threats

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Client #:

Acknowledgement- Receipt of Consent for Treatment

By signing this Client Information and Consent Form as the Client or Guardian of said Client or the client myself, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, The Mahogany Projek, LLC will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.

Printed name of Client	Signature of Client	Date
Printed name of Client	Signature of Client	Date
Printed name of Counselor	Signature of Counselor	Date

Client #:

Acknowledgement- Receipt of Notice of Privacy Practices

By signing this Client Information and Consent Form as the Client or Guardian of said Client or the client myself, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me.

Printed name of Client	Signature of Client	Date

Printed name of Client	Signature of Client	Date

Printed name of Counselor	Signature of Counselor	Date

Acknowledgement- Receipt of No Show/Late Cancellation & Co-payment policy

By signing this Client Information and Consent Form as the Client or Guardian of said Client or the client myself, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me.

Printed name of Client	Signature of Client	Date

Printed name of Client	Signature of Client	Date

Educate. Explore. Acknowledge. Love

Client #:

Printed name of Counselor | Signature of Counselor | Date

Acknowledgement- Receipt of Social Media Policy

By signing this Client Information and Consent Form as the Client or Guardian of said Client or the client myself, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me.

Printed name of Client | Signature of Client | Date

Printed name of Client | Signature of Client | Date

Printed name of Counselor | Signature of Counselor | Date

Authorization to Release Information

If I choose to file with insurance, I authorize The Mahogany Projek, LLC to release my clinical diagnosis, prognosis and treatment request information acquired in the course of my examination or treatment to my insurance carrier. I am also aware that payment Is ultimately my responsibility and should my insurance fail to pay for services for any reason, I am required to pay The Mahogany Projek, LLC for services and reconciling with insurance is my responsibility.

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Client #:

Do you plan to use your insurance to pay for services (covered)? ☐Yes ☐No

Printed name of Client	Signature of Client	Date
Printed name of Client	Signature of Client	Date
Printed name of Counselor	Signature of Counselor	Date

No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $60.00 if I fail to give at least 48-hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $60.00 (which is not paid by insurance) if I fail to show for my appointment.

3. I understand that I am responsible for knowing my co-payment amount and deductible amount. My co-payment amount per session is ______; my deductible amount per year is ___________.
   Have you met your deductible for this year? ☐ YES ☐ NO If no, how much more do you have to pay towards your deductible? _________________

4. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

5. I understand that the therapy session will last 50- minutes (for individual and couple sessions/60 minutes for group). I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

______________________________	______________________________	____________________
Signature of Client /Parent/Guardian	Printed Name of Client	Date

Client #:

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping providers treat you properly.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

____________________________________ ________________

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare/counseling provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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Client #:

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

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It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

____ ____________________

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare/counseling provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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Client #:

CONSENT TO USE OR DISCLOSE HEALTH
INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name: ____

Patient Address: ____

Patient Phone Number: _______________________________________

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your confidential information for purposes of payment may include the submission of your personal information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers of insurers for claims review, determination of benefits and payment; or our submission of your personal information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at our office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform mental health treatment. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or mental health treatment, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY CONFIDENTIAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Patient Signature: ______________________________ Date:____________________________

Client #:

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: ___________________________ Print Name:___________________________________

Limits of Confidentiality Disclosure Form

The purpose of this form is to establish a contractual agreement / understanding between you the client and your licensed therapist/counselor regarding the limits of confidentiality within the counseling relationship. This policy is in keeping with the ethical standards set forth by state licensing boards and professional organizations as well as in keeping with our desire to provide you with quality health care services.

Limits of Confidentiality

It is our desire to protect the privacy of your health data including your verbal report and any written documentation recorded during and/or following sessions with you. However, confidentiality will be breached as required by law and/or ethical standards. For example, a breach will occur in the event of a court order; child abuse or neglect; abuse of a vulnerable adult; potential suicide; homicide or threat of physical harm to a specific identified victim. In addition, licensed professional counselors, certified substance abuse professionals and licensed marriage and family therapists are ethically bound to report any known sexual contact which has occurred between another mental health provider and his/her current or former clients within two years following treatment and/or in some cases in which a health care provider has engaged in unethical behaviors requiring a mandated report in their given field's code of ethics.

In the case of treatment with a minor client, confidentiality is also limited by a parent's "need to know" specifically in those situations that a child is believed to be at risk of harm to self or others and/or in those cases in which a parent or legal guardian specifically requests information as to the child's progress. However, state law and/or ethical standards or practice limit a parent's rights to a minor's mental health information under certain circumstances including a minor female who is pregnant, information pertaining to a student's chemical use, and/or cases in which a minor has separated from their parents and/or legal guardian. Virginia state law authorize that a minor has the right to request that private data about them be kept from their parents. This request will be honored if it is believed to protect a child from physical or psychological harm.

I have read and discussed the information contained in this document with my therapist and understand the aforementioned limits to confidentiality.

Client's Signature______________________________________ Date_________________

Parent/Guardian's Signature______________________________ Date_________________

Social Media Policy

The Mahogany Projek, LLC and its staff has various social media accounts (ie: Facebook, Twitter, LinkedIn and Google+), allowing us to share practice information, news and event updates with other social media users. This document outlines our practice's policy related to use of Social Media. Please read it to understand how we conduct ourselves on the social sites as mental health professionals and how you can expect us to respond to various interactions that may occur between clients and clinicians on the Internet.

This policy is not meant to keep you from sharing that you are in therapy with a therapist wherever and with whomever you like. Confidentiality means that we cannot tell people that you are a client (with limited exceptions). You are encouraged to take your own privacy as seriously as we take our commitment of confidentiality to you.

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Friending: Therapists/Counselors are not permitted to accept "friend" requests from current or former clients on their personal social networking sites (Facebook, Twitter, LinkedIn, etc.). Adding clients as "friends" on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you meet with your therapist/counselor.

Liking/Following: You are welcome to "like" or "follow" our social media feeds and read or share articles we post; however, because social media sites are public spaces, anyone who can see our social media pages can see your post or comment. In addition, when you post, comment, or "like" a page, it will be published on your page as well. Our primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow our practice.

To maintain ethical boundaries, therapists /counselors are not permitted to follow you back. We believe casual viewing of clients' online content outside of the therapy hour can create confusion regarding whether it's being done as a part of your treatment or to satisfy curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on the therapeutic relationship. If there are things from your online life that you wish to share with your therapist, please bring them into the sessions where those things can be viewed and explored with your counselor, during the therapy session.

Messaging: Please do not use wall posting, @ replies, messaging on Social Networking sites to contact your therapist. Engaging with your therapist/counselor in this way could compromise

your confidentiality and the therapist may not even receive your message. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Use of Search Engines: It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Since therapists/counselors are mandated reporters, extremely rare exceptions may be made during times of crisis. If a therapist/counselor has reason to suspect you are in danger and you have not been in touch with your therapist/counselor via usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if your therapist/counselor resorts to such means, the information will be fully documented and discussed with you during your next session.

Business Review Sites: You may find (The Mahogany Projek, LLC) on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find The Mahogany Projek, LLC on any of these sites, please know that this listing is not a request for a testimonial, rating, or endorsement from you as a client. The American Counseling Association's Ethics Code prohibits clinicians from requesting testimonials for marketing purposes.

If you are using these sites to communicate your feelings about your therapeutic experience with your therapist/counselor, the communication may not be seen by your therapist/counselor. You have a right to express yourself on any site you wish; however, due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. Our hope is that you will bring your feelings and reactions concerning your treatment directly into the therapy process. This can be an important part of treatment, even if you decide to go elsewhere.

Location-Based Services (LBS): If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. If you have GPS tracking enabled on your device, it is possible that others may surmise that you are a client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking in" from our office or if you have a passive LBS app enabled on your phone.

Conclusion: Thank you for taking the time to review our Social Media Policy. If you have any questions about anything within this document, you are encouraged to bring them up with your therapist /counselor or contact us. As new technology develops and the Internet changes, there may be times when this policy needs to be updated. You will be notified upon any changes to this policy.

In signing this document, I have reviewed the above information and understand that I will be held to the expectations of this policy.

______________________	______________________	______________
Signature of Patient	Printed Name of Patient	Date

Credit / Debit Card Payment Consent Form

Client ID #: ______________________________

Name on Card if different than client: __________________________

I authorize The Mahogany Projek, LLC to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that The Mahogany Projek, LLC will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge:

Our Fees/Rates

Service	Fee
Diagnostic & Evaluation (90 minutes/1st session)	$150 -175
General Session (Individual and Couple/50 minutes)	$75 - 130
Family Session (60 minutes)	$150
Family Session (90 minutes)	$195
Court Appearance Fee (per hour)	$160
Phone Consultation (30 min)	$50
Group Counseling (Mental Health)	$35 - 45
Substance Use Group Counseling	$20 - 40
Substance Abuse Intake/Evaluation (90 minutes/1st session)	$ 130
Written Reports (Court, etc.)	$ 100
No show fee (If appointment is cancelled within 48 hours of the appointment) is the cost of the appointment	
Come-to-you-counseling (plus travel time/door to door)	$220/hr.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Signature: ______________________

Initials: _____

Date: ________________