LeLyne Joyner, MA LMFT MHC
Informed Consent

Confidentiality: All information disclosed within sessions is confidential. Disclosure may be required under the following circumstances: (a) as mandated by law; (b) to prevent clear and immediate danger to a person or persons; (c) where the therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy; (d) if there is a waiver previously obtained in writing; (e) in the case of a medical emergency during a session in which communication with EMS or other medical practitioners is necessary. Each family member who is legally competent to execute a waiver must agree to the waiver. Otherwise, the therapist cannot disclose any information received unless all legally competent parties sign a waiver.

Emergencies: LeLyne Joyner, MA LMFT MHC does not provide emergency treatment. If you have a medical emergency, LeLyne Joyner, MA LMFT MHC cannot assist you. It is imperative that you do not rely on LeLyne Joyner, MA LMFT MHC in the case of emergencies, but that you do call 911 or visit your local emergency room instead to ensure your safety.

Length of Sessions: Counseling sessions last approximately 45-50 minutes (Play therapy may last less time based on the ability of the child to concentrate)

Payment Options: Payment for each session is due at the begining of each session, prior to the start of the session. Acceptable forms of payment are: Apple Pay or Zelle to 317-272-6208, credit card (additional 4% processing fee will be included), cash, or check made payable to "LeLyne Joyner, MA LMFT MHC".

Insurance: At this time, LeLyne Joyner, MA LMFT MHC is in network with several insurance companies. If the client is a member of one such insurance company, the necessary paperwork and insurance information must be filled out and signed in order to allow payment by the therapist to be received. All co-pays are due at the time of treatment, prior to the start of the session.

Cancellation of Appointments: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is necessary for cancellation. **Sessions that are missed or cancelled without this advance notice shall be billed $110.** Insurance will not pay for a cancelled or missed appointment.

Informed Consent: I affirm that prior to counseling, I was given sufficient information to understand the nature of confidentiality including legal and ethical limits, my counselors professional identity and the nature of counseling. My signature affirms my informed, voluntary consent to receive counseling.

Files: All files kept to record treatment are kept securely in accordance with the federally mandated HIPAA regulations. If you have other parties involved in treatment that are considered clients (marital, conjoint or family therapy),or are co-parents with joint legal custody, the file will be kept together and will be given to the other **authorized** client when requested, according to HIPAA regulations. LeLyne Joyner, MA LMFT MHC is in no way responsible for re-disclosure of records after they may be released to an authorized party.

Communication Options: LeLyne Joyner, MA LMFT MHC can communicate with you in any way that you are comfortable. Texting, emailing and voicemail are not considered HIPAA-compliant forms of communication. However, if you prefer to communicate via text, email, or voicemails, LeLyne Joyner, MA LMFT MHC will communicate in those ways with you. Aditionally, if you would like to meet virtually, LeLyne Joyner, MA LMFT MHC is willing to meet virtually on a platform of the client's choosing, such as Google Duo, FaceTime, MicroSoft Teams, FaceBook Messenger Chat, or Zoom. You must know the security risk before communicating in that way. Please make it clear before you sign below if you are uncomfortable with any form of communication listed.

_____ _____
Client's Signature* Date

_____ _____
Counselor's Signature Date

**The signature of the custodial parent or guardian is required for clients under 18 years of age. If signing for a child, you are affirming you have the right to seek treatment on behalf of this child.*

LeLyne Joyner, MA LMFT MHC

Intake Summary

The following form, which will become a part of your confidential record, will enable me to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name: _____ Date of Birth: _____ Age: ____ Sex __
Last Middle Initial First

Present Address: _____ _____ _____
Street City Zip State

Phone: _____ _____ email: _____
Cell ☐ *Home* ☐ (Select the number I am able to leave messages)

With whom do you presently live, and what is the relationship to you? _____

Marital Status: Single ☐ Married ☐ (# of years _____) Divorced ☐ Separated ☐

Occupation _____ Total hours/week_____

Employed by _____ Years of Education _____

Religious Affiliation _____ Church _____

Referred to LeLyne Joyner, LMFT by _____

Emergency Contact: Name _____ Relationship: _____

Phone _____

If using insurance, please list Insured's Name (if someone other than you): _____

Insured's Date of Birth: _____ Insured's Employer: _____

Insurance Company	ID Number	Group Number	Phone Number

Describe any physical problems you have that require medication or physical care:

Are you currently receiving medical treatment? Yes ☐ No ☐
Are you currently taking any prescription drugs? Yes ☐ No ☐ If yes, please list:

Are you currently pregnant? Yes ☐ No ☐
Have you ever had an abortion or participated in a girlfriend's/wife's abortion? Yes ☐ No ☐

Have you ever been in counseling before? Yes ☐ No ☐ If yes, when? _____
What was the reason for terminating counseling?

Please check each symptom you are or have experienced. If you have had, or are experiencing, other symptoms not listed, please also check "Other" and provide a description of the additional symptom(s).

- ☐ Disassociative episodes
- ☐ Thoughts of hopelessness
- ☐ Thoughts of worthlessness
- ☐ Recent changes in appetite
- ☐ Recent changes in desire or ability to sleep
- ☐ Panic attacks
- ☐ Inability to concentrate
- ☐ Fatigue
- ☐ Fidgeting consistently
- ☐ Lack of motivation
- ☐ Hearing voices that others don't hear
- ☐ Seeing things others don't see
- ☐ Desire to avoid certain places or people
- ☐ Nightmares
- ☐ Episodes in which you display another personality
- ☐ Other:
- ☐ Consistent worrying
- ☐ Tension in jaw and other parts of the body
- ☐ Inability to keep long-term friends
- ☐ Consistent pain in body
- ☐ Consistent sadness without knowing why
- ☐ Feelings of irritability without explanation
- ☐ Feelings of impatience
- ☐ Desire for more out of life
- ☐ Feelings of isolation
- ☐ Lack of initiating relationships
- ☐ Changes in sexual appetite
- ☐ Brain fog or mental confusion
- ☐ Loss of memory
- ☐ Flashbacks

Please check each item which identifies an area of concern to you.

- ☐ Anger
- ☐ Depression
- ☐ Education
- ☐ Eating Difficulties
- ☐ Anxiety
- ☐ Financial Problems
- ☐ Marital Problems
- ☐ Physical Problems
- ☐ Social Problems
- ☐ Problems with Children
- ☐ Problems with Parents
- ☐ Physical Abuse
- ☐ Divorce
- ☐ Religious/Spiritual Concern
- ☐ Sexual Concerns
- ☐ Thoughts of Suicide
- ☐ Trouble making decisions
- ☐ Abortion or miscarriage
- ☐ Use of Alcohol
- ☐ Use of Alcohol by family member
- ☐ Use of Drugs
- ☐ Work
- ☐ Worry
- ☐ Grief
- ☐ Sexual Abuse
- ☐ Separation

I have read the Informed Consent and voluntarily request counseling services with LeLyne Joyner, MA LMFT MHC in accordance with the terms described.

_____

Signature*

_____

Date

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