Consent to Treatment

Welcome! I am looking forward to working with you to help you achieve your goals in counseling. I appreciate the fact that you are here to make positive changes in your life. I also understand that this can be challenging and overwhelming. However, I promise it will be worth it. I want to make this journey as comfortable and productive as possible. To do so, I have provided below an important document for you to review. This will provide you with some of the answers to the questions you may have about our experience together. Please read it carefully and make note of any questions that you may have for me. I will gladly discuss them in our session. This document will represent our professional agreement with one another.

About Taylor

Taylor Barchowski is a Licensed Mental Health Counselor (MH23946) and a Nationally Certified Counselor, Certified Equine-Assisted Therapist, and a Certified Trauma Informed Yoga Instructor. I approach therapy as a collaborative effort between the therapist and the client and/or family. I work with adolescents and adults struggling with depression, anxiety, transitions, self-esteem, and many other areas. I also believe therapy is a place where clients can safely and securely challenge their unwanted behaviors and thought processes; part of my job is to address said behaviors that may be negatively affecting the clients' daily life. We will work together to create healthy coping skills and boundaries to work towards achieving outlined goals. If you ever have questions about my therapeutic intervention, please know you can ask at any time. If you feel the treatment plan we have formulated together is not working, please know you can reach out at any time and address it with me. I am more than happy to talk about it and work through it with you. It is imperative to mention that you have confidentiality. However, please note that I am a mandated reporter. Please take comfort in the fact that this means if I have any indication of abuse and/or neglect, I must report it to the appropriate authorities. If you report suicidal and/or homicidal ideation, and a plan as well as follow through, I must report it to the appropriate authorities for your safety.

Therapeutic Services

Therapeutic services can be an intensive experience. It requires the hard-work and dedication of the client and clinician. Please be aware that counseling can be difficult at times, but this often has positive results. However, the positive results may come with time, and I ask that you have faith in yourself and the process. If at any time, you are having feelings of anger, frustration, sadness, or guilt, I ask that you be honest so that we can discuss it. Change is often uncomfortable, but that does not mean it is not worth it. Your interpersonal relationships may change as you see yourself evolve. This is due to new self-discovery and understanding. I hope to see you learn and apply positive, healthy coping mechanisms while going through this process. I believe everyone has coping mechanisms that works, they just may not have figured out what it is yet. We will work together to discover yours. My therapeutic interventions are based upon the need for each individual that comes into therapy. I will be honest and transparent as to what interventions I am using to provide psychoeducation. Additionally, I will assign "homework" to encourage you to continue practicing what we are working on outside of the session. Different types of treatment may be appropriate for the same issue, and you will be informed of the pros and cons of the different approaches. You will be actively involved in deciding the forms of treatment that best address your needs. It is equally important to commit to the process outside of our session as it is to do so in each session. During any time of our relationship, if I see that you are engaging in destructive or self-harming behaviors, I will discuss it with you. I want our relationship to be honest. If need be, I will recommend community referrals to include possible psychiatric care, medical evaluation, and/or supplemental treatment. In certain situations, my continuance of services will be dependent on your willingness to participate in additional treatment recommendations.

Hours/Days of Operation

The hours of operation change with the season to accommodate my clients. My typical days of operation are Sunday through Thursday. I see clients both in-person and virtually. I normally book out 2 weeks in advance. If I have a cancellation, I will reach out to ask if you'd like an earlier day.

Communication

If you are experiencing a medical or mental health emergency, please contact 988, 911, or 211, the local Crisis Hotline. You can also text Crisis Text Line at 741-741. They are available to you 24/7. If you are unable to do so, please go to your nearest hospital/emergency room. I will be available to you via phone call. Please do not send texts as it could violate your confidentiality. However, due to my schedule and the nature of my work, I may not be able to get back to you immediately. When making contact, please leave a voicemail so that I know to return your phone call. Please do not text or email emergencies. If I know that I will be unavailable for an extended period, I will let you know, and we can make appropriate arrangements if necessary. If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face-to-face sessions are highly preferable to phone sessions. However, if you are unable to make it into the office, virtual is not an option due to location/privacy, and need additional support, phone sessions are available. If you should choose to communicate with me via email, I cannot guarantee your confidentiality as sometimes an email remains on a server and may be accessible by others. My email address is lifesinsession.counselingco@gmail.com. If you plan to communicate via email please limit it to scheduling and cancelling appointments, and refrain from revealing details about yourself, as I will do the same.

Termination

The thought of termination can often be anxiety provoking. However, it can be positive and a sign of independence. It is my hope that you will be more than capable of utilizing positive and healthy coping mechanisms over time so that you can deal with whatever situation arises in your life. Termination will be based upon progress and treatment goals, which will be collaboratively decided upon. We will continuously discuss termination as you reach your goals and objectives. You may discontinue counseling at any time. If you or I determine that you are not benefiting from treatment, you or I may discuss termination and/or a referral for alternative treatment. As previously noted, continuously cancelling, or not keeping scheduled appointments, as well as not following the recommended treatment plan may result in termination.

Our Agreement to Enter into Counseling Services

I have read or had read to me all the information in this above paperwork, have initialed where applicable indicating that I have read them and understand them, have had a chance to review and ask questions and havehad all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment for myself and/or child and understand all the benefits and risks of counseling as outlined herein.

Printed Name Client's Signature Date

Taylor Barchowski • LMHC #23946 • Life's in Session Counseling Co. • lifesinsession.counselingco@gmail.com • (732)589-8171

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I am required to abide by the terms of this Notice of Privacy Practices. I may change the terms of this notice at any time. Upon your request, I will provide you with any revised Notice of Privacy Practices.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow me to use and disclose your health information in the following categories. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

- Psychotherapy Notes. I do keep "psychotherapy notes" and any use or disclosure of such notes requires your authorization unless the use or disclosure is:
    - ○ For my use in treating you.
    - ○ For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
    - ○ For my use in defending myself in legal proceedings instituted by you.
    - ○ For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
    - ○ Required by law and the use or disclosure is limited to the requirements of such law.
    - ○Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
    - ○ Required by a coroner who is performing duties authorized by law.
    - ○Required to help avert a serious threat to the health and safety of others.
- Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
- Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION: Subject to certain limitations in the law, I can use and disclose your PHI without your authorization for the following reasons:

- When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
- For health oversight activities, including audits and investigations.
- For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an authorization from you before doing so.
- For law enforcement purposes, including reporting crimes occurring on my premises.
- To coroners or medical examiners, when such individuals are performing duties authorized by law.
- For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
- Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
- For workers' compensation purposes. Although my preference is to obtain an authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
- Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me.

CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT: Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

- The right to request Limits on uses and disclosures of your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believed it would affect your health care.
- The right to request restrictions for out-of-pocket expenses paid for in full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.The right to choose how I send PHI to you. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
- The right to see and get copies of your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you.
- The right to get a list of the disclosures I have made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an authorization.
- The right to correct or update your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why.
- The right to get a paper or electronic copy of this notice. You have the right get a paper copy of this notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this notice via email, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Printed Name Client Signature Date

Taylor Barchowski • LMHC #23946 • Life's in Session Counseling Co. • lifesinsession.counselingco@gmail.com • (732)589-8171

Consent for Electronic Communication

It may become useful during treatment to communicate by email, text message (e.g., "SMS"), fax, voicemail, or other electronic methods of communication. Be advised that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept these messages. Also, if you choose to send emails, texts, fax or voicemails, they will be part of your clinical record.

Some of the potential risks you might encounter using these methods of communication include:

- People in your home or other environments who access your phone, computer, or other devices that you use might read your email or text messages.
- Loss of cellular phone, computer, or other devices.
- Email accounts can be hacked.
- Text messages and emails are stored on servers.
- Misdelivery of email to an incorrectly typed address.
- Third parties on the Internet such as server administrators who monitor Internet traffic might intercept your communication.

Email communication is not appropriate for all circumstances. Please remember the following:

- Emails are not to be used for emergencies or time-sensitive issues.
- Emails are not to be used as a therapy session.
- No one can guarantee the privacy of e-mail messages.

Texting is a convenient method of communicating brief information, but it is not secure. Please remember the following:

- Not for emergencies
- Not to be used for therapy services
- To be used as a reminder or services only
- No one can guarantee the privacy of text messages.

Please check the unsecured methods in which you approve to be contacted for appointment reminders, receive receipts, psycho-educational material etc.:

☐ Email

☐ Text

☐ Voicemail

☐ Other

ACKNOWLEDGEMENT OF CONSENT FOR ELECTRONIC COMMUNICATION

My signature below indicates I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Printed Name Client Signature Date

Non-Recording and Social Media Policy

Non-Recording Agreement

Successful therapy depends on building a relationship of trust, good faith, and openness between client(s) and therapist(s). Often, audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all the other persons in the room. In addition, recordings made and taken home by clients sometimes fall into unintended hands through loss, random or targeted theft, or action by police, court or governmental agency. Such loss will compromise and nullify your confidentiality in the therapy space as you are violating your own confidentiality (i.e., parents, partners, friends, and social media). Recording may only take place with the knowledge and explicit consent of ALL (not just one) clients, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.

Social Media Platforms

Social media is a good way of keeping people connected and informed. I sometimes use social media for my practice, so I have created a social media policy to help you understand my intentions, and how I will be using social media in my practice. The basis for this policy is to protect our relationship and your confidentiality during therapy and beyond.

Confidentiality

If you decide to tell others about your sessions with me, or the progress made with your therapy, that is entirely your choice. However, I must keep my relationship with you completely confidential except in cases of where you might harm yourself or others. Please note that recording our sessions without permission and/or uploading them to social media is a direct violation of the therapeutic relationship and may be cause for termination.

Friending

In order to respect your privacy and confidentiality, I do not accept friend requests from current or former clients on social networking sites (Facebook, LinkedIn, etc.) or any other social media platform. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality. It may also blur the boundaries of our therapeutic relationship. I 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 personal 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 our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together.

Interacting

Please do not use messaging on social networking sites such as Instagram, Facebook, LinkedIn or any other, to contact me. These sites are not secure, and I may not read these messages in a timely fashion. The best way to interact with me is by email or phone. If you post on my Facebook feed, 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.

Search Engines

I do not "Google" my clients or look up information on them for any reason. If I do come across your information online, I will move on and avoid reading content.

Business Review Sites

You may find my business in an online directory. Some of these sites include places where users can provide ratings and reviews. Many of these sites scrape search engines for businesses and automatically add entries, regardless of whether the business has added itself to the site. If you should find my business on any of these sites, please know that my listing is not a request for a testimonial, rating, or endorsement from you as my client. You have a right to express yourself on any site you wish, but I am not asking you to do so. If you do post a review, I cannot respond on any of these sites, whether it is positive or negative.

Location Based Services

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.

Email

I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not 100% secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of both your and my internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider.

Text

Sometimes clients text me to request an appointment time or to let me know if they are running late to an appointment. Please know that text isn't always secure. I am fine with brief texts related to your appointment only.

Conclusion

I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy.

ACKNOWLEDGEMENT OF NON-RECORDING AND SOCIAL MEDIA POLICY

My signature below indicates I have been informed of the risks, including but not limited to my confidentiality in treatment, by engaging with my my provider through social media or online channels. I agree that if I record and/or share recordings of our therapy sessions, it will call for immediate termination of services.

Printed Name Client Signature Date

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Billing and Payment Policy

Life's In Session Counseling Co. is dedicated to providing you with high-quality mental health care.

Clients wishing to use insurance benefits need to provide ***Headway*** with their current insurance information when scheduling the first appointment. This includes secondary insurance, if applicable.

Verification of benefits is not a guarantee of payment and it is the client's responsibility to call the customer service number on the back of their insurance card to have a full understanding of what services are covered in addition to knowledge of your co-pay, deductible, and co-insurance prior to your initial appointment. It is also the client's responsibility to notify ***Life's In Session Counseling Co.*** of any insurance changes. I am happy to provide you with the appropriate paperwork for you to file with your insurance company for out-of-network reimbursement, if you are not covered by the insurances I am credentialed with. I cannot guarantee your insurance company will reimburse for my services.

Clients are required to pay for all sessions at the time of service unless client is utilizing insurance benefits. Those not using insurance are required to have a valid credit card on file. Therapy fees are ***$125*** per session if paying via IVY Pay, or ***$120*** via Zelle, cash, or check.

Acceptable methods of payment are cash, check, HSA/FSA, Zelle, and credit card payments.

I understand situations arise where you may need to request written documentation. In many circumstances, I am happy to accommodate those requests. Time to write letters, fill out forms, or complete other documentation at a client's request (this does not include phone calls with other providers on your treatment team, i.e. general practitioner, psychiatrist), is billed at **$125**. This includes any time needed to review records, notes, or other documents necessary to complete the request.

Written Acknowledgment of Billing and Payment Policies

Check One Box for Payment For Service (check one):

☐ I authorize ***Life's In Session Counseling Co.*** to release all billing and medical information regarding my diagnosis and therapy and/or medication treatment, and substance abuse if applicable to any third-party payer, when such information is requested for payment utilization review or coverage determination purposes.
I am making payment for services directly; therefore, I am not authorizing a release of information for billing purposes.

Acknowledgment of Policy (initial ALL indicating your understanding)

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or canceled until payment is received.
I understand that court, document, and report fees are to be paid by client.
I understand ***Life's in Session Counseling Co.*** is not responsible for maintaining active insurance status and will contact ***Headway*** regarding insurance questions and concerns.

I have read this document and it has been explained to me. I understand and agree to the terms. My signature below means that I understand and agree with all the points above.

Printed Name Client's Signature Date

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Cancellation and No-Show Policies

CANCELLATION OF SCHEDULED APPOINTMENTS MUST BE DONE 48 HOURS PRIOR TO APPOINTMENT.

If the 48-hour cancellation requirement is not met, a *"Late Cancel"* fee will be assessed. If you have an emergency, you will not be charged. If a client is able to reschedule the missed appointment within the same week, fees will not be assessed. If you are running late for your appointment, please call to let me know. If you arrive late, the session will still end on time to avoid someone else's appointment and you will still be responsible for the full payment. If you have a set time slot and are continuously late or cancel 2 times in a row, that slot may be opened to others. If there is a pattern of cancellations, I will address it with you and may need to provide you with outside referrals. *"No-Shows"* will result in a **$120** fee.

Normally, at the end of each session, we schedule and/or confirm our next regularly scheduled appointment. If you choose to not schedule or cancel and we are not in communication for 3 weeks, your file will be moved to "inactive" status, meaning we are not actively working together. If/when you choose to return, there is no guarantee that my schedule will be the same or that I will have availability; therefore, you may be placed on a waitlist.

Written Acknowledgment of Cancellation and No-Show Policies

Acknowledgment of Policy (initial ALL indicating your understanding)

I understand that reminder notifications for ongoing sessions are a courtesy and will be made via email or text messaging. I understand that I am responsible to remember and attend my scheduled appointments.

I understand ***Life's In Session Counseling Co.*** cancellation/change policies and agree to provide the required notification if I must cancel/change my appointment.

I understand that if fees are not paid in full, treatment sessions may be postponed or canceled until payment is received.

I have read this document and it has been explained to me. I understand and agree to the terms. My signature below means that I understand and agree with all the points above.

Printed Name Client's Signature Date

Court Policy

Please be advised that the therapist, ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co.***, does not participate in person, by phone or in writing in any court related matter that the client of ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co.***, may be a party to or become a party to in any way. ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co.,*** does not write letters regarding their client's treatment to any entity, including the judiciary. ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co.***, at no time, will offer an opinion or recommendation in any court matter, especially as it relates to custody. However, if the client requests a subpoena for therapist ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co***., or provides the information of that therapist for subpoena, the client will be responsible for the court fees outlined in this court policy.

If a court order is served and is requesting that the therapist ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co.***, be present in person and/ or there is a request for records, the client's consent will be requested before turning over confidential information. When obtaining this consent, the client will be told exactly what has been requested by court and client understands that there is no guarantee that the information will be kept confidential and ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co.***, will not be responsible for any disclosure. This includes a client's mental health history; status and inclusive records and may not be in the best interest of the client. The therapist client relationship does not render the therapist as an advocate. The therapist will withhold any opportunity to engage in a dual relationship with the client. If called to testify in a deposition or court hearing, the client may not discern between information and records provided. All information and records are available for discovery. This may not be in the best interests of the client. The therapist reserves the right to discuss the implications of releasing information and records.

Court Policy & Fees

Please be advised that should Taylor Barchowski, LMHC, NCC or Life's in Session Counseling Co., be court ordered to appear in court or at a deposition, the fee stipulation is as follows:

- ***$800*** per day plus ***$100*** per hour for travel to and from the court.
- ***$200*** per hour for preparation.
- ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co***., will NOT be ON-CALL at any time. Should a case be trialed, or continued, the therapist will be paid in full for each day as well as an additional $200 per day as it hinders the therapist's or supervisors' ability to be available to their other clients.

Subpoenas

Please coordinate with ***Taylor Barchowski, LMHC***, or ***Life's in Session Counseling Co.***, to ensure that the therapist can be available for the date and time of the deposition or court hearing. The therapist may agree to accept the subpoena via email if agreed upon. Reminder: A subpoena in which the client provided the therapist as a potential witness shall be billed in full for all court related activity. All court fees must be received by 7 days prior to the court date by the client. Should the court, calendar the hearing for another date, the therapist must be re-issued a new subpoena with the new court hearing date. Should the therapist be on vacation, the party initiating the court order must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena.

ACKNOWLEDGEMENT OF RECEIPT OF COURT POLICY:

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT INCLUDING THE ABOVE STATED COURT POLICY AND STIPULATION, INCLUDING BUT NOT LIMITED TO THE FEE STRUCTURE FOR ALL RELATED COURT MATTERS.

Printed Name Signature Date

Provider: Taylor Barchowski, LMHC
Practice: Life's in Session Counseling Co.
License #: MH23946
Taxonomy Code: 101YM0800X
NPI #: 1376283705
Billing Address: 3030 Starkey Ranch Blvd.
Trinity, FL 34655

LIFE'S
IN SESSION COUNSELING CO.
PSYCHOTHERAPY & WELLNESS SERVICES

General Information

Name | Date of Birth | Age

Address

City | State | Zip Code

Phone # | Email

Is it ok to leave messages at this phone number? ☐ Yes ☐ No May I contact you via email? ☐ Yes ☐ No

Emergency Contact Name | Phone #

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

Preferred pronouns

Spirituality

Community Involvement:

Family Involvement

Family Information

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Spouse/Partner | Age | Lives with you? ☐ Y ☐ N

How satisfied are you with your relationship? ☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very Unsatisfied

Do you have children? ☐ Yes ☐ No If no, please skip to the next section.

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

Child | Age | Lives with you? ☐ Y ☐ N

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LIFE'S
IN SESSION COUNSELING CO.
PSYCHOTHERAPY & WELLNESS SERVICES

Family History

Who were you raised by?

How many siblings do you have?

Please describe your relationship with your parents/caregivers:

Please describe names, ages, and respective relationships with your siblings:

If there are any circumstances from your childhood that you'd like to elaborate on, please do so here:

Support System

Do you have a support system? ☐ Yes ☐ No

Please explain:

What is your current living situation?

Is your home environment safe? ☐ Yes ☐ No

If no, please explain why:

Employment/Education Status

Employer/School

Occupation/Years in School

Please check all that apply:

- ☐ Disabled
- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Retired
- ☐ Unemployed
- ☐ Student

What is your highest level of education completed?

- ☐ Less Than High School
- ☐ High School/GED
- ☐ Associates Degree
- ☐ Some College
- ☐ Bachelor's Degree Post
- ☐ Graduate Degree

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Mental Health History

Have you experienced any of the following in the past 90 days? Please check all that apply:

- ☐ ADHD
- ☐ Anger/Rage
- ☐ Anxiety
- ☐ Death in Family
- ☐ Depression
- ☐ Hallucinations
- ☐ Hospitalization
- ☐ Obsessive/Intrusive
- ☐ Thoughts Mood Swings
- ☐ Panic/Phobia
- ☐ Paranoia/Delusions
- ☐ Poor Sleep Patterns
- ☐ Racing Thoughts
- ☐ Self Injury
- ☐ Suicide Attempt
- ☐ Thoughts of Harming
- ☐ Others Violence
- ☐ Weight Gain/Loss

Have you experienced abuse? ☐ Yes ☐ No

If yes, please explain:

Have you ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes, please explain:

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes, please explain:

Have you had therapy in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous therapist Dates seen

Medical History

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Have you had any surgeries or operations? ☐ Yes ☐ No

If yes, please list:

Do you currently have any medical problems? ☐ Yes ☐ No

If yes, please list all symptoms and treatments you are undergoing:

Do you experience physical pain that causes mental health issues? ☐ Yes ☐ No

Physician Phone Number

Permission to contact physician? ☐ Yes ☐ No

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Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- ☐ Alcohol/Drug Abuse Attempted
- ☐ Suicide
- ☐ Death
- ☐ Debilitating Injuries/Disabilities
- ☐ Divorce
- ☐ Financial Crisis/Job Loss
- ☐ Relocations
- ☐ Legal Problems
- ☐ Physical/Sexual Abuse
- ☐ Psychiatric Illness
- ☐ Serious Illness
- ☐ Other _____

Personal History

What symptoms are you dealing with? Please check all that apply:

- ☐ Appetite Problems
- ☐ Concentration Problems
- ☐ Energy Levels
- ☐ Flashbacks
- ☐ Hopelessness
- ☐ Low Interest/Motivation
- ☐ Mood Swings
- ☐ Nightmares
- ☐ OCD Symptoms
- ☐ Panic Attacks
- ☐ Thoughts of Self-harm/Suicide
- ☐ Trouble Sleeping
- ☐ Other _____

How long have you been dealing with these?

What effect do these have on your life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Habits & Lifestyle

Do you regularly drink alcohol? ☐ Yes ☐ No

If yes, how often: Are you dealing with any addictions? ☐ Yes ☐ No

If yes, please explain:

How often do you engage in recreational drug use? ☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your alcohol/drug use a problem? ☐ Yes ☐ No ☐ Unsure

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe what you do and how often:

Do you have hobbies? ☐ Yes ☐ No

If yes, what are they and how often do you do them?

What do you do for fun?

Legal Summary

Have you or are you dealing with any of the following legal issues? Please check all that apply:

- ☐ Custody/Divorce
- ☐ Driving Offenses
- ☐ Fraud
- ☐ Immigration
- ☐ Substance Abuse
- ☐ Violence

Have you ever been imprisoned? ☐ Yes ☐ No

If yes, please explain:

Are you court ordered for services ☐ Yes ☐ No If no, please skip to the next section.

If yes, please list them here: Name: Phone Number:

Will you require progress reports for legal authorities? ☐ Yes ☐ No

Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning?

What do you hope to get from treatment?

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PHQ-9 and GAD-7 Assessment Form

PHQ-9: Patient Health Questionnaire

1. Little interest or pleasure in doing things
   ○ 0 ○ 1 ○ 2 ○ 3
2. Feeling down, depressed, or hopeless
   ○ 0 ○ 1 ○ 2 ○ 3
3. Trouble falling or staying asleep, or sleeping too much
   ○ 0 ○ 1 ○ 2 ○ 3
4. Feeling tired or having little energy
   ○ 0 ○ 1 ○ 2 ○ 3
5. Poor appetite or overeating
   ○ 0 ○ 1 ○ 2 ○ 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
   ○ 0 ○ 1 ○ 2 ○ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television
   ○ 0 ○ 1 ○ 2 ○ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being more fidgety or restless than usual
   ○ 0 ○ 1 ○ 2 ○ 3
9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way
   ○ 0 ○ 1 ○ 2 ○ 3

GAD-7: Generalized Anxiety Disorder Assessment

1. Feeling nervous, anxious, or on edge
   ○ 0 ○ 1 ○ 2 ○ 3
2. Not being able to stop or control worrying
   ○ 0 ○ 1 ○ 2 ○ 3
3. Worrying too much about different things
   ○ 0 ○ 1 ○ 2 ○ 3
4. Trouble relaxing
   ○ 0 ○ 1 ○ 2 ○ 3
5. Being so restless that it is hard to sit still
   ○ 0 ○ 1 ○ 2 ○ 3
6. Becoming easily annoyed or irritable
   ○ 0 ○ 1 ○ 2 ○ 3
7. Feeling afraid as if something awful might happen
   ○ 0 ○ 1 ○ 2 ○ 3

PHQ-9 Total Score: ☐

GAD-7 Total Score: ☐