Jan Seltzer, M.S., LPC
Licensed Professional Counselor
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(214) 597-4686

Professional Disclosure Statement

Welcome! The information you are about to read may be helpful in explaining questions you might have regarding the therapy/counseling experience. Typical areas of concern will be addressed.

Qualifications and Background: I am a Licensed Professional Counselor in the state of Texas, with a Master's degree in Counseling and Development and a Bachelors degree in Psychology from Texas Woman's University. I worked at the Denton County Jail for three years, as an intern, counseling with female and male inmates with an array of personalities and offenses, individually, and in groups. I am a Certified Parent-to-Parent Family Trainer on ADHD, and a former board member of the North Texas Chapter of CHADD, (Children and Adults with Attention Deficit Disorder) in Dallas. I enjoy working with couples, teaching relationship skills and communication strategies. I work with various anxiety, depression, anger management, other learning disabilities and/or co-existing disorders that come with ADHD. I am also a Certified Trauma Specialist, dealing with all types of abuse, along with a special interest in High- Functioning Autism. My continuing formal education, professional experience, and life experience, enable me to develop a certain sense of comfortableness, safety, and rapport with my clients. I am prepared to counsel individuals, couples, and groups.

My mission statement and orientation of counseling: Every human being has the potential to create a fulfilling and authentic life. You have the capacity to learn to make healthy choices, to investigate and to achieve needs, goals, desires, and to find meaning and purpose in your life; To be able to experience all emotions and define them. All individuals will face joys and sorrows, trials and tribulations throughout life. They are a given of our existence. You are capable of self-awareness; gaining the knowledge to learn to develop and increase healthy coping, and behavioral strategies, while decreasing ones that are not working. I will use an integrative approach to meet your treatment related goals with your permission, with the ultimate goal of filling your toolbox with knowledge, self-awareness, and the tools needed for change to occur. I remain faithful to my commitment to be responsive and empathetic to your thoughts and feelings. I am highly committed to your continual personal growth. Together, in a collaborative relationship, it is possible to stimulate change.

INFORMED CONSENT Counseling Relationship: Our sessions will begin promptly on the hour and will last approximately one hour. Our counseling sessions may be very intimate psychologically; however, it is important to know our relationship is a professional one rather than a personal one. Our contact will be limited to counseling sessions arranged by appointment only. You may leave a message for me at 214) 597-4686. I will return your call as soon as possible. In the case of an emergency or crisis, you can obtain crisis services by calling 911 and/or going to a nearby hospital emergency room.

Effects of Counseling: The effects of counseling are varied. At any time during our process, you may initiate and express any positive or negative thoughts or feelings about our experience together, your progress, or lack thereof. Benefits from counseling are certainly preferred; however, specific results are not guaranteed. Know that during the therapeutic process changes may occur and can sometimes be temporarily distressing. Significant relationships might change as a result of your personal growth and self- understanding. My intention is that change can occur through our genuine therapeutic relationship.

Client Rights: Each client is different regarding the amount of necessary counseling sessions to achieve their goals. As a client, you are in complete control and may end our counseling relationship at any time. I do request; however, that you participate in a termination session. You have the right to discuss with me and modify any counseling technique or suggestions you may deem as not beneficial. I assure you that my

services will be rendered in a professional manner consistent with legal and ethical standards. If you are dissatisfied, at any time, with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the State Board of Examiners of Professional Counselors at (512) 834-6658.

Fees: For a fee of $90 per one-hour session, I agree to provide counseling services for you. This fee will be paid at the conclusion of each session. Cash, personal checks, or credit will be acceptable forms of payment. If this fee presents a hardship for you, please let me know. Payment plans may be optional depending on proof of individual or family income. I also take certain forms of insurance listed on my website. Fees will be doubled for time spent on any necessary document preparation, court costs, depositions, or testifying in court for any legal proceeding due to the complexity and difficulties of legal involvement. I do not file for reimbursement from health insurance companies I do not accept; however, should you have insurance, a bill of services may be provided, so you can file it on your own.

Cancellations: I value your time. If you are unable to make your scheduled appointment, please notify me at (214) 597-4686, at least 24 hours in advance. In the event of a missed appointment or lack of 24 hours notice, you will be billed for half the fee of $45.00.

Referrals: I realize that not all conditions presented by clients are appropriate for treatment at this facility. Certain aspects of treatment may require evaluation through psychological testing, alternative programs, or medication. In such cases, a referral to a medical doctor or a psychiatrist may be made. Ongoing dialogue with these professionals would be maintained to manage the counseling process effectively. Should you and/or I believe that a referral is necessary, I will provide alternatives that may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Conditions of Ongoing Counseling: If you have been in counseling during the past seven years, I may require you to sign a release so I may communicate with and/or receive copies of records from the professional(s) from which you received mental health services. While in counseling with me, you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with me and sign a release that enables me to communicate with the other mental health professional(s). If you decide to maintain or establish a relationship with another mental health professional against my advice, I may consider this your decision to change counselors and I reserve the right to terminate your counseling.

Records and Confidentiality: All communication becomes a part of a clinical record. Records are kept for seven years after the file is closed, then disposed of. Minor client records are disposed of seven years after their 18th birthday.

Our communication is strictly confidential, except for the following limitations and exceptions: (1) I am using case records for purposes of professional development. In these cases, I will identify you by first name only to preserve confidentiality; (2) I determine you are in danger to yourself and/or others; (3) you disclose sexual contact with another mental health professional; (4) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; (5) I am ordered by a court to disclose information; (6) you direct me to release your records; (7) I am otherwise required by law to disclose information. In the case of couple's counseling, I reserve the right to terminate the counseling relationship if I judge a secret to be detrimental to the therapeutic process. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. By your signature below, you are indicating that you have read and understood this statement, and that any questions you had about this statement have been answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Client Signature_____ Date_____

2nd Client Signature_____ Date_____ Counselor Signature_____ Date

Jan Seltzer, MS, LPC

Licensed Professional Counselor (LPC)

GENERAL INFORMED CONSENT FOR THERAPY

Clients usually enter counseling because they seek some positive benefits. Psychotherapy and counseling have some risks as well as benefits. Just talking about your history and concerns can have both positive and negative effects. I want to inform you of the possible risks as well the potential benefits as you begin therapy. During the first session, I will confirm with you in writing your understanding of the limits of confidentiality, the risks and benefits of verbal therapy, and the expectations of you as a client. I will determine with you the methods, goals, or objectives of your counseling after I have collected some of the history regarding the issues.

Any type of therapy will have certain benefits and specific risks associated with it. When I recommend a definite type of therapy, I will discuss the reasons for choosing that type of method. I will also discuss any additional benefits as well as risks associated with my recommendations. If the situation warrants, I may recommend other types of care including a referral to your family physician for an evaluation. It is your decision whether to follow my recommendation. The most universal concerns of my clients are difficulties with depression, anxiety, and problems with interpersonal relationships. Most of my clients enter counseling because they want to change some of their own behavior.

In the following paragraphs I have summarized some of the usual benefits that my clients experience with counseling. I have also identified some of the risks associated with almost any kind of verbal therapy.

Potential benefits of therapy

1. *Improved understanding of self and others.* The objective viewpoint of the counselor helps many clients better understand their own feelings and behavior as well as those of others.
2. *Progress toward defined goals and objectives.* In therapy, the clients and counselor work toward those goals. Most clients can clearly identify the changes in feelings and behavior that they make through therapy.
3. *Greater sense of control over moods and behavior.* As clients measure progress and identify the tools used to make headway, they often gain feelings of power over moods and behavior.
4. *Improved self-esteem.* With greater self-control, clients often improve their self-concept. Confronting and managing one's difficulties often leads to improved self-esteem.
5. *Improved self-assertion.* Many clients increase their ability to assert themselves. As self- esteem and feelings of self-control improve, they feel more able to stand up for their own rights without infringing on the rights of others.
6. *Improved relationships with others.* By reducing unwanted behaviors and increasing more desirable behaviors, clients often improve relationships with family members or co-workers or friends.
7. *Improved capacity for independence.* Before therapy many of my clients may have depend on others for their sense of well-being. Therapy may lead to an increased ability to meet one's own needs.

Potential risks of therapy

1. *Lack of progress.* Some clients do not appear to improve in therapy. For example, depression or anxiety may become worse. I will monitor your progress with you to determine if this happens and to plan alternatives should this occur. In some cases I may recommend a different form of care or may suggest care by another provider or provide referrals to other providers.

2 . *Upsetting insight.* Therapy may lead to insight into your own behavior or the behavior of others that is upsetting. Some clients, following therapy, wish they had not discovered some things about themselves or others. Of course, once you are aware of new information, there is no going back. I will monitor your feelings with you and discuss these concerns if they arise.

3. *Feelings of distress.* Discussing personal concerns can be upsetting by itself. Clients may experience feelings of *sadness, anger, anxiety, or depression* in talking about their personal or family difficulties. Clients may also have bad dreams or nightmares as a result of talking about concerns. Part of therapy often involves learning to handle such feelings more effectively when they occur. I will work with you to develop coping strategies for these feelings if they arise.

4. *Change in relationships.* Although behaviors and moods may change in a way that the client desires, others may not like the changes and may not adjust to the changes the client makes. Improvements in client's self-esteem, self-assertion, or sense of self-control may negatively affect others. Verbal therapy can lead to *conflict in marriage* or other family relationships. Sexual relationships can deteriorate. Sometimes verbal therapy can lead to divorce. Therapy may also lead, in rare cases, to deterioration of relationships at work and can result in the loss of a job. In some cases the client decides to make changes in the family, to seek divorce, or to change jobs. However, *other individuals with whom the client has a relationship may initiate changes when the client does not want to do so.* I will work closely with you to try to anticipate such problems in therapy. However, we cannot anticipate all interpersonal conflicts that may result from therapy.

I have reviewed the risks and benefits of general verbal therapy as explained in this document. My counselor has adequately answered any questions I have regarding these risks and benefits. I agree to enter verbal therapy with an understanding of the possible risks. I further understand that my counselor will explain any additional specific risks and benefits associated with any particular method, goals or objectives he/she may recommend.

_____

Client Name (Print)

_____

Client Signature

Date _____

I have interviewed the above named individual(s) and have answered any questions about the risks and benefits of general verbal therapy. On the basis of my interview I have no reason to believe that he/she or they are not competent to understand the nature of verbal therapy and the potential risks and benefits that may result from it.

Jan Seltzer, MS, LPC

Provider name Signature Date

_____

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HIPPA NOTICE OF PRIVACY PRACTICES

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

Effective August 1, 2004

Use and disclosure of protected health information for the purposes of providing professional counseling services is sometimes required. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Treatment Use and disclose health information to:

- Provide, manage or coordinate care to consultants, referral sources, or physicians.
- As patients gives permission via “Informed Consent” form.

Healthcare Operations

- Use and disclose health information for:
- Review of treatment procedures. Review of business activities.

  Staff training and care within our practice.
- Compliance and licensing activities.

Other Uses and Disclosures Without Your Consent

- Mandated reporting.
- Emergencies.
- Criminal damage.
- Appointment scheduling.
- Treatment alternatives.

As required by law. By signing below, you attest that you have read and have been made aware of my rights of confidentiality as a mental health consumer. Full HIPPA Compliance Rules and Regulations are posted in the counselor’s office at all times, and may be read and copied for consumer upon request.

_____

Client/Guardian Printed Name

Relationship to Client _____

_____

Client/Guardian Signature Date Signed _____

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CLIENT REGISTRATION FORM

Name _____ Date of Birth _____ Age _____

Residential Address _____ City _____ Zip_____

OK to send treatment/billing information to this mailing address? Yes No

If no, please provide an alternative mailing address:_____

Home Phone: _____ Messages OK? Yes No

Cell Phone:_____ Messages OK? Yes No

Other Phone:_____ Messages OK? Yes No

Email:_____ Messages OK? Yes No

Relationship Status: Single / Married / Committed Relationship / Divorced / Separated / Widowed / Co-Habitation / Other

Emergency Contact: Name_____ Relationship to you:_____

Home Phone:_____ Other Phone:_____

Primary Care Physician:_____ Phone:_____

Referred by: Insurance Co. / Physician / Friend / Other:_____

INTAKE QUESTIONNAIRE

What brought you into counseling/therapy today?_____

_____

What do you wish to change or accomplish as a result of therapy?_____

_____

Have you been in therapy before? Yes No If yes, please state when and where:

_____

Was it a positive experience? Yes No What did you like/not like about it?

_____

Reflecting on the last six months, please check all that apply:

___ Frequently sad or depressed
___ Overwhelming worries
___ Difficulty falling asleep or staying asleep
___ Unable to concentrate
___ Irritable and/or short temper
___ Significant change in weight
___ Low energy level/fatigue
___ Feeling excessive guilt or shame
___ Unable to relax
___ Lack of appetite/increased appetite
___ Loss of interest in activities/hobbies
___ Feeling hopeless
___ Feeling worthless
___ Difficulty motivating
___ Withdrawn/isolating self
___ Cry easily/often
___ Difficulty making a decision
___ Difficulty finishing tasks
___ Thoughts to hurt self
___ Attempts to harm yourself
___ Thoughts to hurt others
___ Threats to hurt others
___ Feeling ill/sick
___ Stomach aches/vomiting
___ Headaches/migraines

___ Feeling restless or keyed up
___ Restless unsatisfying sleep
___ Muscle tension
___ Mood Swings
___ Decreased need for sleep (only need 3-4 hours)
___ Feel more talkative than usual
___ Excessive spending/shopping
___ Excessive gambling
___ Easily distracted by unimportant things
___ Take too many risks
___ Troubling thoughts about the past
___ Nightmares
___ Startle easily
___ Too neat and orderly
___ Repeating certain behaviors over and over
___ Easily upset or angered
___ Feeling different from most people
___ Shy around others
___ Increasingly forgetful
___ Strong fears
___ Difficulty with work or school
___ Use of sedatives

Medical History

Have you consulted a physician or psychiatrist regarding the problem which brings you here?
Yes No _____
Are you currently being treated for any medical problems? Yes No
Are you currently taking any medication? Yes No

List medications:

Dosage	Type	For (i.e. depression)	Prescribed by

Are you currently taking over the counter medications, herbs, or supplements? Yes No

Are you presently in good health? Yes No

Do you engage in any physical activity? Yes No

If yes, what activity?_____ How often?_____

Do you smoke cigarettes? (cigars, chew)? Yes No #___ per day

How much alcohol do you drink? #____ per day_____# per week

Do you drink caffeinated beverages? Yes No If yes, how many per day? _____

Do you use illicit drugs? Yes No

If yes, how often and what drugs do you use?_____

Have you ever tried to cut down or stop using alcohol or drugs? Yes No

Has anyone ever asked you to cut down on your drinking? Yes No

Have you ever been hospitalized for any emotional/ mental health condition? Yes No

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Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one, etc)*	*Yes*	*No*
Do you have a history of domestic violence?	Yes	No
Do you have a history of verbal, emotional, or physical abuse?	Yes	No
Do you have a history of sexual abuse or sexual assault?	Yes	No

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SUPPORT SYSTEMS

Do you have one or two friends that you consider close and feel close and feel you can depend on?	Yes	No

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Do you have a religion or spiritual practice that you experience as supportive?	Yes	No

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Do you belong to any social groups or participate in hobbies with people that you enjoy?

Yes No

Is there a family member that you trust and can go to in times of emotional need? Yes No

Are there other people or aspects of your life that you consider supportive? Yes No

FAMILY HISTORY

Have you or anyone in your family ever experienced any of the following? If yes, please note their relationship to you. Please include extended family (i.e. Grandparents, Aunts, etc.)

Has anyone experienced: Family Member (s):

Anxiety

Depression

Bipolar Disorder

Learning Disorders (ADHD, dyslexia, etc.)

Illicit drug use

Alcohol abuse

Schizophrenia

Anger

Eating Disorder

Phobias

Hospitalization for Mental Health Condition

Attempted or completed suicide

Please circle any of the following areas that you would like to address in therapy.

Family
Parenting
Children
Relationships
Alcohol or Drug use
Verbal abuse
Physical abuse
Emotional abuse
Sexual abuse
Finances
Self-growth and Awareness
Career/education
Phase of life
Stress
Assertiveness
Health problems
Childhood experiences
Loss or death
Spirituality
Self-esteem
Legal issues
Other

Thank you for your time and consideration!
Jan