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WELCOME

Welcome to New Vision Professional Counseling. You are embarking on a journey in counseling that has the potential to determine your course beginning in this life and extending into eternity. During your counseling experience you will be provided several opportunities to make positive changes in your life through daily good decisions in your thoughts and behaviors. Numerous will be the amount of assignments given and books to read on the path to God's best in your life. Consider these opportunities to grow and make success in love and life part of your normal culture. For many what I have expressed thus far will remain a dream or a distant thought that will forever remain just out of their reach. My prayer is that you are different.

Just as we will provide you with several opportunities to succeed, the devil will provide you with even more (countless) opportunities to fail. Frequently they are one and the same because obstacles are God's invitation to trust and overcome through faith. On the other side of the coin, the devil uses obstacles to tempt us to fail. We only fail when we refuse God's fatherly guidance and elect to follow our naturally selfish ways of handling these obstacles. The choice is yours.

The same principle remains true in counseling. You will have the opportunity to do all your assignments and follow the counselor's suggestions without excuse and watch your life progressively get better. Or you can hope that the therapist will wave his magic wand and your spouse will change, your depression and anxiety will immediately disappear, and all the problems that brought you to counseling will miraculously be solved. Well that would be great, but unfortunately not realistic. This business of helping people takes time. Consider how long it took the problems you are experiencing to develop. It is not reasonable to expect them to be solved in a few sessions. ***However, if you position yourself to run a marathon and engage in your effort accordingly, then great will be the outcome of your counseling experience. For many are the sprinters who come to counseling desperate and leave as soon as the crisis dissolves and they are able to successfully return to their fortress of denial until the next crisis forces them out.***

So friends, the choice is yours as it has always been. Soon you will begin learning how to effectively work through your issues and the underlying pain causing or resulting from them. My prayer is that you surrender control to God and trust Him to lead you where you must go to be healed. He who set the stars in their places and created the world and everything in it is more than capable to handle the affairs of your daily and eternal life. Make the decision to not judge God by your circumstances, but to always judge your circumstances by God. Your circumstances change constantly, but *our Loving Heavenly Father never has and never will change.* And as demonstrated by sending Jesus Christ to pay the penalty for your sins, *His Heart is always for you.* Have you ever demonstrated that kind of love toward another or had someone demonstrate that kind of love toward you? The Good News is that you will be given the opportunity to truly get to know and experience God's Love in *Authentic Relationship* as a crucial part of your counseling journey.

I look forward to working with you and am excited to see all the great and wonderful things God will do through someone completely dedicated to Him in word and deep. May the God of Love, fill you with hope, as you trust in Him.

Sincerely,

_____

Shawn Maguire, LPC

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Informed Consent for Treatment

I, _____, give consent for evaluation and treatment to be provided for myself/my child, _____, by __*Shawn Maguire, LPC.*

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risks, benefits, side effects and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me, and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree and commit to play an active role in my treatment process.

I understand there is a **"Zero Tolerance"** policy for any **violent/aggressive actions,** words (threats), gestures, and the like. At the discretion of the attending therapist these actions will result in immediate termination. We will not compromise safety and will maintain this boundary for the benefit of all.

I understand I will be charged the full hourly fee if I "no-show" for an appointment or do not provide at least a twenty-four (24) hour notice of cancellation.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Printed Name (Relationship if not Patient) Date

_____ _____
Witness Signature Date

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Patient Information

Today's Date: _____

Patient's Full Legal Name: _____

Patient's Preferred Name: _____ Age: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Please circle best contact number: Home_____ Cell _____ Work _____

Email: _____

May we correspond with you via email regarding billing and counseling information? Yes _____ No _____

Social Security Number: _____ Employer: _____ Occupation: _____

Marital Status: _____ Name of Spouse: _____

Primary Care Physician: _____ Phone: _____

Nearest Relative (not living at same address): _____ Relationship: _____ Phone: _____

Persons with whom we may discuss your medical care (please list with contact number):

_____ _____

Person financially responsible: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

How were you referred to our office? _____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

May we contact you by e-mail if necessary? _____

HISTORY OF PRESENT PROBLEM

Purpose of this appointment: _____
_____

Have you ever had the same or a similar condition? _____Yes _____No
If yes, when and describe: _____
_____

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PAST HISTORY

Do you ever have (Place a check mark by conditions that apply to you):

__ Anxiety __Eating Disorder __ Depression __ Post Traumatic Stress Disorder
__ Anger __ Adoption Issues __ Abandonment __ Other_____
__ Alcoholism __ Drug Addiction __ HIV Positive __ Other_____
Have you had any major illness, hospitalizations, or surgeries? Please include dates. (Women, please include information about childbirth): _____
_____
_____
_____

Have you been treated for any health condition by a physician in the last year? __ Yes__ No
If yes, describe: _____

What medications or drugs are you taking? (List name and dosage) _____
_____

Please list any other health problems you have, no matter how insignificant they may be:
_____
_____
_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? ____ If so, packs per day: _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

Do you sleep well at night? _____ If no, why not? _____

What are your hobbies? _____
_____
_____
_____
_____
_____

What percentage of time during the day (at home or at your job away from home) do you spend: Under normal stress: ___% Under considerable stress: ___% Resting or relaxed: ___%

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FAMILY HISTORY

Parents:
Father: living ___ deceased ____ (check one) Current age if still living: _____ Cause of death and age at death if deceased: _____

Mother: living ___ deceased ____ (check one) Current age if still living: _____ Cause of death and age at death if deceased: _____

Check if applicable to you:
___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list:
_____

FAMILY DISEASES
(if applicable, indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__ Anxiety __ Eating Disorder __ Depression __ Post Traumatic Stress Disorder
__Anger __ Adoption Issues __ Abandonment __ Other_____
__ Alcoholism __ Drug Addiction __ HIV Positive ___ Other_____

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Case History

1. What is your major concern?

   _____
   _____
   _____

   Other concerns:

   _____
   _____
   _____

2. If this is a recurrence, when was the first time you noticed this problem?

   _____
   How did it originally occur? _____
   _____
   Has it become worse recently? Yes __ No __ Same __ Better __ Gradually Worse __
   If yes, when and how? _____
   _____

3. How frequent is the condition? Constant _____ Intermittent ____
   What causes the problem to come on/get worse? _____
   _____

4. Are there any other conditions you would like to discuss?
   Yes _____ No _____ If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____ If yes, describe _____
   _____

5. Is there anything you can do to relieve your major problem? Yes ___ No ___
   If yes, describe: _____
   If no, what have you tried to do that has not helped? _____
   _____

6. What makes the problem worse? _____
   _____

NO SYMPTOMS/STRESS — EXTREME SYMPTOMS/STRESS

Please place an "X" on the line above to indicate level of problem.

Therapist's Signature_____ Date _____

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ADULT HISTORY FORM

Name_____ Date_____ DOB_____ Age_____

SOCIAL HISTORY:

Date of Birth:_____ Age:_____ Place of Birth:_____

Where did you grow up? _____

Did your family move around? If yes, please describe:

How many siblings do you have?

Which family members are you close to?

Describe your childhood:

Were you ever abused (physically, sexually, emotionally)?

Who did you rely on for emotional support?

Do you have any type of belief system (moral, spiritual, cultural, religious) that influences your life?

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RELATIONSHIP HISTORY:

What is your sexual orientation?

What is your marital status? ___ Single ___ Married ___Divorced ___Widowed ___Separated ___ Other

Describe your current relationship, including any stressors:

Describe any prior marriages or long term relationships and the reason for the divorce/break up:

Patient Name_____

List any children you have including their names and ages:

Any problems with your children?

List all people currently residing in your home:

RISK ASSESSMENT:

	Past	Now
Have you ever had thoughts of hurting yourself?	_____	_____
Have you ever had thoughts of committing suicide?	_____	_____
Have you ever had a plan to commit suicide?	_____	_____
Have you ever made threats to kill yourself?	_____	_____
Have you ever made a suicide attempt?	_____	_____
Have ever mutilated yourself?	_____	_____
Have you ever had thoughts of harming someone?	_____	_____
Have you ever had plans to harm someone?	_____	_____
Have you ever attempted to harm someone?	_____	_____
Have you ever made threats to harm someone?	_____	_____

Is there any other information that would be helpful for your counselor to know?

_____ _____

Your Signature Date

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Brief MAST

Client Name_____ **Date**_____

Client Completes

___ yes ___ no Do you feel you are a normal drinker?

___ yes ___ no Do friends or relatives think you are a normal drinker?

___ yes ___ no Have you ever attended a meeting of Alcoholics Anonymous (AA)?

___ yes ___ no Have you ever lost friends or girlfriends/boyfriends because of drinking?

___ yes ___ no Have you ever gotten into trouble because of drinking?

___ yes ___ no Have you ever neglected your obligations, your family, and/or your work for two or more days in a row because of drinking?

___ yes ___ no Have you ever had delirium tremens (DTs), severe shaking, heard voices or seen things that were not there after heavy drinking?

___ yes ___ no Have you ever gone to anyone for help about your drinking?

___ yes ___ no Have you ever been in a hospital because of drinking?

___ yes ___ no Have you ever been arrested for drunk driving or driving after drinking?

***The Brief MAST is based on the Michigan Alcoholism Screen Test developed by M. Selzer *(American Journal of Psychiatry* 27(12): 1653-1658, 1971.) Pokomy, Miller and Kaplan presented the brief version in the *American Journal of Psychiatry* 129(3): 342-345, 1972.

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Client Information and Office Policy Statement

New Client: Welcome!
Thank you for choosing New Vision Professional Counseling. We would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies. Your therapist will answer any questions you have regarding any of these policies.

Getting to Know You
In the first session you complete introductory paperwork and meet with your clinician. You will talk about your reasons for coming and your current situation. You will be asked questions about the history of your family as well as your own history. You and your clinician will make a treatment plan focusing on your behavioral health needs within your first two sessions. The frequency of your sessions will be based on your individual assessment.

Treatment Process
You and your therapist will work together to identify treatment goals and options. The length of time in treatment will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about the problem you are experiencing so that your clinician can better assist you in treatment planning.

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

- Increasing personal awareness
- Increasing personal responsibility and acceptance to make changes necessary to attain your goals
- Identify personal treatment goals
- Promoting wholeness through psychological and spiritual healing and growth

You are expected to play an active role in your treatment including working with your therapist to outline your treatment goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments. *Your progress in therapy depends much more on what **you do** between sessions than on what happens in the session.*

Your Clinician
Shawn Maguire has a Bachelor's Degree in Psychology, a Master's degree in Marriage and Family Therapy, and a Master's degree in Christian Counseling. Upon completing the educational, supervision, and passing his state licensing board exams, the Oklahoma Department of Mental Health has certified Shawn Maguire as a Licensed Professional Counselor (LPC). He has over a decade of experience working with families, marriages, adults, and children. He has published articles on relationships, mental health issues, and leadership in magazines and newspapers. He also conducts marriage seminars and workshops for churches and the community. His life goal is to help people discover the healing power of God on route to reaching their destiny.

Clinician Responsibilities
Your clinician is responsible for providing you with quality professional service. This includes treating you with respect, maintaining your confidentiality (see below) and informing you about your condition/diagnosis and treatment options. Information about treatment options will include potential benefits and risks associated with those options. In order to meet these responsibilities, your clinician may consult with other clinicians as necessary. This would be discussed with you.

Confidentiality
Written permission is required to release any information to another agency or to receive any information from another agency. The only exceptions to this policy occur when the clinician has concerns about possible elder or child abuse/neglect or when the clinician believes there is serious threat of self-harm or harm to others. Clinicians are required by law to notify appropriate persons/agencies under these circumstances.

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Patient Responsibilities

Office hours are Monday through Friday and flexible depending on the amount of patients at any given time. It is important that you are on time for your appointments and that you call 24 hours in advance when you are unable to keep your scheduled appointment. Failure to show up for your appointment or failure to cancel with at least a prior 24 hour notice will result in a charge to you of the full usual and customary fee or, if you covered under a managed care policy, the full contracted fee with your managed care company for the scheduled service that was missed. There are no exceptions to this policy.

After Hours

This office is not designed to be an emergency facility. In the event of an emergency call 911 or go to your local emergency room for assistance. For urgent needs contact your primary care physician or leave a message with your therapist. He will usually return your call within 36 hours, except on weekends and/or holidays.

Fee Policy

As a courtesy, we will verify, pre-certify and submit your insurance claim. Your benefits, costs, and copayments as they pertain to your treatment will be discussed with you. Any amount that your insurance company will not be paying is due from you at the time services are rendered. If there are problems with meeting financial obligations, please inform your counselor. You are responsible for providing this office with copies of your insurance card(s) or any changes with your insurance or coverage. Failure to do so may result in a denial of your claim.

Paperwork

There are times when you may need paperwork completed by the clinician. There is a fee for filling out forms and reports. The fees vary according to the document(s) needed. Paperwork and forms can take up to sixty minutes or more to be completed. Be sure to drop paperwork off to this office as early as possible.

Your Satisfaction is Important to Us

Please feel free to raise any concerns with your clinician at any time. If you are dissatisfied with this office we ask that you speak with your clinician.

Patient Signature_____ Date_____

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Consent to Treatment of Minor

I_____ hereby give consent for New Vision Professional Counseling and the staff and employees to treat _____ as a client/patient as of this date, _____.

_____ _____
Signature of parent or guardian Date

_____ _____
Witness Date

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Emergency Contact Numbers to Call After Hours

New Vision Professional Counseling is not a counseling practice that provides 24 hour emergency service for those in crisis. However, we understand there are times when you may require immediate assistance. Therefore we provide you with the following list of agencies that are advertised as being available either "after hours" or 24 hours. We assume no association with or responsibility for any of the agencies listed below. We do not advocate one over another. We are completely indep';,.';endent of all the agencies listed below and are not liable for any information or treatment they provide for you. Once again, we assume zero responsibility for their actions. This list is not meant to be exhaustive or all-inclusive. The numbers below are simply provided as a service to help you in the event you are not able to make contact with your therapist in a crisis situation.

911	All Emergencies
211	24 Hour Crisis Hotline
1-800-273-8255	24 Hour Lifeline/Suicide Hotline
1-800-522-9054	Reach Out (Mental, Health, Substance Abuse, Domestic/Sexual Violence) Hotline
(405) 235-9812	Lend a Hand Parent Child Center
(405) 307-5555	Norman Regional Hospital Behavioral Medicine Center
(405) 272-6216 (405) 272-4900	Saint Anthony Behavioral Medicine
(405) 951-2331	Integris Mental Health
(405) 949-1866	Women's Crisis Services
(405) 232-2709	City Rescue Mission
(405) 232-7164	Jesus House
(405) 848-2273	Family Telephone Helpline

By signing below, you are stating that you have been given a copy of this emergency contact sheet. You are also stating that you have been provided with an opportunity to ask any questions regarding how and when to use these numbers.

_____ _____

Client Signature Date

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Patient Health Information Consent Form HIPPA

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Patient_____ Date_____

For further information regarding this notice, please contact our therapist at (405) 921-7776.

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AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

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Patient Rights & Responsibilities

In the course of care a patient has both rights and responsibilities. I understand that I have the right to:

- Be treated with respect and recognition of my dignity and right to privacy
- Receive care that is considerate and respects my personal values and belief system
- Personal privacy and confidentiality of information
- Receive information about my managed care company's services, practitioners, clinical guidelines, quality improvement program and patient rights and responsibilities
- Reasonable access to care regardless of my race, religion, gender, sexual orientation, ethnicity, age or disability
- Participate in an informed way in the decision making process regarding my treatment planning
- Discuss with my treating professionals appropriate or medically necessary treatment options for my condition regardless of cost or benefit coverage
- Have family members participate in treatment planning and if I am over the age of 12 to participate in such planning
- Individualized treatment, including:
    - Adequate and humane services regardless of the source(s) of financial support
    - Provision of services within the least restrictive environment possible
    - An individualized treatment or program plan
    - Periodic review of the treatment or program plan
    - An adequate number of competent, qualified and experienced professional clinical staff to supervise and carry out the treatment or program plan
- Participate in the consideration of ethical issues that arise in the provision of care and services, including:
    - Resolving conflict
    - Withholding resuscitative services
    - Forgoing or withdrawing life-sustaining treatment
    - Participating in investigational studies or clinical trials
- Designate a surrogate decision maker if I am incapable of understanding a proposed treatment or procedure or am unable to communicate my wishes regarding care
- Be informed, along with my family, of my rights in a language I/we understand
- Voice complaints or appeals about my managed care company, provider of care or privacy practices
- Make recommendations regarding my managed care company's rights and responsibilities policies
- Be informed of rules and regulations concerning my own conduct
- Be informed of the reason for any utilization management adverse determination including the specific utilization review criteria or benefits provision used in determination
- Have utilization management decisions based on appropriateness of care
- Request access to my Protected Health Information (PHI) or other records that are in the possession of my managed care company
- Request to inspect and obtain a copy of my PHI, to amend my PHI or to restrict the use of my PHI, and to receive an accounting of disclosures of PHI

I understand that I am responsible for:

Providing (to the extent possible) my treating clinician and managed care company with information needed in order to receive appropriate care:

Following plans and instructions for care that I have agreed on with my treating clinician

- Understanding my health problems and participating, to the degree possible, in developing, with my treating clinician, mutually agreed upon treatment goals

_____ _____ _____ _____

Patient/Guardian Signature Date Clinician Signature Date

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Patient Self-Evaluation

Name_____ **Date**_____

1. Circle all areas you would like help with:

   Depression Anger Anxiety Fear Hate Low Self-Esteem Assertiveness
   Co-dependency Aggression Domestic Violence Parenting Marriage
   Relationship(s) Health Pain Legal Past Please list others: _____
   _____ _____ _____ _____ _____

2. On a scale of 1 to 10, rate your current life satisfaction: _____
   (1= life is hell on earth and 10= life is heaven on earth)

3. Do you believe you **<u>can</u>** improve your life satisfaction?

4. How far are you willing to go to receive help? In other words, how committed are you---to you?

5. What is your biggest fear, and how does it affect you?

6. What will your life be like in the future if you continue to do things the way you are now? In other words, what will happen if you choose not to change?

   One Year:
   Five Years:
   Twenty Years:

7. What you want your life to look life in one, five, and twenty years from now?

   One Year:
   Five Years:
   Twenty Years:

8. What are you three most important goals?

   1)
   2)
   3)

9. On a scale of 1 to 10 (with 10 being the maximum you level of dedication), how committed are you to accomplishing your goals. What are you willing to sacrifice? How much time, effort and money are you willing to invest? Are you willing to face and work through the pain associated with growth? Will you seek out and accept accountability to achieve these goals? Will you make achieving these goals a pritority?

10. List at least three specific actions you can take this week to remove the roadblocks and work toward your goals:

    1)
    2)
    3)

11. How will you know our time together has been successful? How will your life be different?

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Refusal to Pay Bill and Behavioral and Compliance Policies 1

Payment Policies: All payments are due in full *at the time of service(s)* and are to be paid by cash, check, or credit card at the beginning of sessions before counseling is to begin. It is the therapist's right and at his discretion to utilize his option of writing off any charges for services rendered and/or to do any portion of counseling paperwork, etc. pro bono. However any dispute over a bill, *renders all previously written off charges void*, and ***all fees will be reinstated***.

If the patient or other responsible party fails to pay his/her bill **within ten (10) days** of services rendered, than any and all charges for counseling, paperwork, and any other service rendered by the therapist/NVPC ***will be charged*** to the client or other responsible party *even if the charges were previously written off.* If the patient or other responsible party fails to pay his/her bill **within thirty (30) days** of services rendered, the client ***will be required to pay*** all attorney fees, filing charges, lost wages from work, and compensation for any time required of the therapist to reclaim the debt owed by said client or responsible party.

Behavioral and Compliant Policies: If the client/responsible party or any other person related to the client by blood or association threatens the therapist or any other individual associated with New Vision Professional Counseling (NVPC) in any way whatsoever, *the following guidelines will apply and be strictly enforced*: The aforementioned person(s) ***will not*** be allowed on the premises of New Vision Professional Counseling; ***may not*** contact in person, by phone, mail, email, or text the therapist or any other individual associated with New Vision Professional Counseling; ***will not*** go to the homes of the therapist, other employees of or any other individual(s) associated with New Vision Professional Counseling; and furthermore ***will not*** speak to, threaten, harass, stalk said person(s) in any way, shape, or form thereof. *If any of these guidelines are violated, charges will be pressed with local authorities and a Victim Protective Order (VPO) will be filed.*

Furthermore, if the client/responsible party or anyone on behalf of the client makes a complaint against the therapist, *the client/responsible party will pay* New Vision Professional Counseling's/the therapist's *attorney and legal fees in full* for said entity/person(s) to dispute the claim. If the therapist is found not guilty and said claim against the therapist was decided upon to be unfounded, *the client/responsible party will pay* for the therapist's *lost wages* from work during the hours of 8 am to 5 pm and *any other time required* of the therapist to settle the matter *at the rate of* ***$150.00*** *per hour* as well as provide compensation for any other expenses that may occur during or as a result of the claim. If any harassment, threat(s)/threatening behavior, damaging remarks or slander has occurred against the therapist or New Vision Professional Counseling, *a minimum of* ***$1,000.00*** *in damages will be awarded* for forcing said therapist to endure this hardship. Also, the therapist *will prosecute* any individual(s) or party that libels the name and/or reputation of the therapist and/or the entity of New Vision Professional Counseling and will additionally *seek compensation for all damages* up to the full extent allowable by law.

It is the goal of your therapist at New Vision Professional Counseling to help you and your family. This document, explanation of policies, and the language used herein is ***required*** to be signed by all clients and individuals associated with or receiving services through New Vision Professional Counseling to ensure the safety and well-being of all clients and individuals as well as diminish any misunderstanding that may occur by providing information, explaining procedures, and allowing for an opportunity to ask questions. Thank you for your understanding and cooperation in this matter. By signing below you are stating that you have read, understand, and agree to all the terms and conditions stated above as well as assume complete and total responsibility to satisfy them in full.

Patient Signature_____ Date_____

Responsible Party Signature_____ Date_____