MINOR CLIENT REGISTRATION

Please print clearly and provide all of the requested information. This information is for internal use only and is intended to establish a confidential client file.

MINOR INFORMATION (client)

Client's Full Legal Name_____

Client's Date of Birth _____/_____/_____ Email_____

Client's Address_____

City_____ State_____ Zip_____

Home: ( ) _____ - _____ Cell: ( ) _____ - _____ May we leave a voicemail: Y N

Non-Parent Emergency Contact:_____ _____ (____)_____ - _____
Name Relationship Telephone

PARENT/GUARDIAN #1 INFORMATION

Name_____ Relation to client_____

Date of Birth _____/_____/_____ Email_____

Address (if different from above) _____

City_____State_____Zip_____

Home: ( ) _____ - _____ Cell: ( ) _____ - _____ May we leave a voicemail: Y N

PARENT/GUARDIAN #2 INFORMATION

Name_____ Relation to client_____

Date of Birth _____/_____/_____ Email_____

Address (if different from above) _____

City_____State_____Zip_____

Home: ( ) _____ - _____ Cell: ( ) _____ - _____ May we leave a voicemail: Y N

FINANCIAL RESPONSIBILITY

I understand that I am responsible for the full payment of all fees and that payment is expected at the time services are rendered. I also understand that when a portion of my fees are to be paid by another party, I am ultimately responsible for full payment of fees, especially missed session fees that are never billed to third parties. Appointments not cancelled at least 48 hours in advance will be considered a "no show" and charged the full rate for the missed session.

HIPAA PRIVACY NOTICE

I have read the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices and have had the chance to have any of my questions answered. The Notice of Privacy Practices can be found at https://www.revisionchristiancounseling.com/forms/. I acknowledge that if I want to receive a paper copy of the Notice of Privacy Policies, I can request one.

_____ _____

Client Signature (if able) **Date**

_____ _____

Parent/Guardian #1 Signature **Date**

_____ _____

Parent/Guardian #1 Signature **Date**

REVISION
CHRISTIAN COUNSELING

INFORMED CONSENT

The purpose of the Informed Consent is to define the relationship between the client and the counselor at Revision Christian Counseling, LLC ("Revision").

At Revision, we believe in the power of the therapeutic relationship to foster growth, healing, and transformation. Our primary goal is to provide a safe, non-judgmental space where you can freely express your thoughts, emotions, and experiences. Through this collaborative alliance, we aim to help you achieve your therapeutic goals. The benefits of a therapeutic relationship are numerous: increased self-esteem, enhanced coping skills, improved relationships, and a deeper understanding of yourself and others. Moreover, by working with a trained therapist, you gain access to professional expertise and evidence-based interventions tailored to your specific needs.

However, it is important to acknowledge the potential risks inherent in participating in therapy. During the therapeutic process, you may experience temporary discomfort as you explore challenging or painful experiences. It is not uncommon to feel vulnerable, anxious, or overwhelmed at times. Additionally, therapy may bring to light aspects of yourself or your relationships that you may find difficult to confront. However, our skilled counselors are trained to guide you through these uncomfortable moments with sensitivity and care, ensuring that you feel supported throughout the process. We believe these temporary discomforts often pave the way for lasting positive change and personal growth.

While therapy can be transformative, it is a collaborative effort that requires your active participation and commitment. It may take time and consistent effort to achieve your desired outcomes. Additionally, the therapeutic relationship relies on confidentiality and ethical guidelines, ensuring that your privacy is respected and protected. Revision strictly adheres to these principles, promoting a safe and confidential space for your therapeutic journey.

PHILOSOPHY

We believe it ethically responsible to inform you that our world view is influenced by our Christian beliefs. You do not have to believe what we believe for us to serve you well. We seek to neither spiritually manipulate clients nor force religion on them, we strive to reflect the character and grace of Jesus Christ in all we do. As trained professionals we also find that medical science, professional research, and specific treatment methods may be helpful in identifying problems and applying appropriate interventions.

CONSENT TO COUNSELING

I consent to enter into a counseling relationship with _____.

I understand that I am free to terminate counseling at any time and my counselor can provide me with a referral that may better serve my needs. As part of my treatment team, Revision counselors serving me may discuss my case with one another for my benefit. They also may discuss my case without any identifying information as a part of their case review.

The following staff counselors engage in weekly supervision and may discuss your case with their specified supervisor for the licensure process. Interns also engage in supervision and may discuss your case with a faculty member at their affiliate graduate program listed below.

Taylor Jacks – supervised by Christina Basham 2016041662
Zenny Jua – Covenant Theological Seminary intern
Jen Ryu – Covenant Theological Seminary intern

FEE AGREEMENT

I have reviewed, completed, and signed the **Client Registration Form** and agree to pay _____ per 50-minute session (therapeutic hour) for counseling upon services rendered. I understand the counseling session may go longer than 50 minutes. I agree to pay for any extra time spent in counseling.

If I do not cancel an appointment with at least 48 hours' notice, I understand that I will be charged the full amount for the missed session. Also, if I am late for a scheduled appointment, I understand that we will end on time and I will be charged for the entire scheduled appointment.

LEGAL DISCLOSURE

As a general practice, we do not participate in our clients' legal proceedings and do not think it is within our therapeutic role to be called as a witness as it can be detrimental to the counselor/client relationship. If we are subpoenaed or court-ordered to proceedings on your behalf, you are agreeing to abide by this legal disclosure and pay our fees. The charge for such services is currently $220 per hour for preparation, travel, and attendance at any legal proceeding, with a minimum three-hour charge due before the proceedings. This fee schedule also applies to any legal documentation we are asked to complete on your behalf.

Should a client become involved in legal proceedings that may require an RCC staff member's participation, the client shall be billed for his or her counselor's professional time, even if called to testify by another party. Attendance at legal proceedings is at the discretion of the staff person, based on the best ethical practice for the client, unless attendance is mandated by subpoena or court order.

RECORDS RELEASE POLICY

I understand that my client file is confidential and will be maintained by Revision. Client files remain the sole property of Revision and will only be released to a third party pursuant to my valid, written and notarized authorization, a valid subpoena issued by a judge, or by Order of a Court of competent jurisdiction.

Any requests for records of a client who is a minor shall be made by a valid, written authorization signed by all caregivers, who have or share legal custody of the minor.

Upon termination of services, client files are securely stored for 8 years after which they are destroyed.

REVISION
CHRISTIAN COUNSELING

CONFIDENTIALITY

With the exception of certain specific exceptions described below, I have the absolute right to the confidentiality of my therapy. My counselor cannot and will not tell anyone else what I have said, or even that I am in therapy without my prior written permission. Under the provisions of the Health Care Information Act of 1992, my counselor may legally speak to another health care provider or a member of my family about me without my prior consent in the event of an emergency.

I may direct my counselor to share information with whomever I choose by signing a release of information, and I can change my mind and revoke that permission at any time. I may request anyone I wish to attend a therapy session with me. The following are legal exceptions to my right to confidentiality. My counselor will make every effort to inform me if any of the exceptions below apply.

1. If my counselor has good reason to believe I will harm another person, my counselor must attempt to inform that person and must also contact the police and ask them to protect my intended victim.
2. If my counselor has good reason to believe I am in imminent danger of harming myself, my counselor may legally break confidentiality and call the police and/or my emergency contact.
3. If my counselor has good reason to believe I am abusing or neglecting a child or vulnerable adult, or if I give my counselor a name and information about someone else who is, my counselor must inform Child Protective Services.
4. If my counselor is subpoenaed by the court to testify or release client information
5. If a parent or legal guardian of a minor requests information about me (if under 18)
6. While this last point is not a legal matter, it is a policy you need to be made aware of if participating in couples counseling. If my partner and I decide to have individual sessions as a part of couples counseling, I understand that what I say in individual sessions will be considered part of the couples counseling. I will not disclose anything I wish kept confidential from my partner.

TECHNOLOGY

If I elect to communicate by email, I am aware that email is not completely confidential. By using email, I understand that there is no guarantee that privacy will not be breached and I, therefore, assume all risk if my privacy is breached. All emails are retained in the logs of my or my counselor's internet service provider. Any email my counselor receives from me and any responses sent to me may be printed and kept in my client file.

I also agree to avoid texting my counselor with protected health information, as this means of communicating is not HIPAA compliant. The only exception is information directly related to scheduling, provided I do not give protected health information.

If I have thoughts of self-harm, suicide, or harming others, I agree not to use email or texting to communicate this to my counselor and will instead contact emergency services or go to the nearest hospital.

REVISION
CHRISTIAN COUNSELING

TELEHEALTH

When it has been determined to best meet the needs of a client, Revision offers a telehealth (defined as using secure video or phone communication) option for counseling to clients who are currently within the State of Missouri or living outside the United States. By initialing the appropriate statements below, I agree to participate in a telehealth session(s) with my therapist at my own risk and under the terms and legal procedures governing the State of Missouri's licensing of such practice of professional mental health counseling.

There are noticeable differences between telehealth and in-person counseling. Telehealth may limit the counselor's ability to perceive non-verbal cues and/or cause misunderstandings in communication due to technological difficulties. In addition, there are potential privacy concerns present in telehealth. Therefore, as a client, you must understand the risk of participating in telehealth.

_____ I give my consent to use video conferencing for telehealth sessions. I understand that my therapist only uses Google Meet for video telehealth sessions and, while it is HIPAA compliant, there are still risks to doing telehealth.

_____ I give my consent to use the telephone for my telehealth and I understand that phone calls between cell phones are not secure. While landlines are more secure, there is no guarantee that privacy will not be breached. I, therefore, assume all risk if my privacy is breached.

_____ I acknowledge the potential risk of compromise to my confidentiality by using audio or visual telecommunication and wish to proceed knowing these risks.

_____ I understand that I have the option to change my mind about any of my choices listed above and I will do so in writing.

_____ I understand that in the event of a technology failure during an audio or visual telecommunication session immediate steps will be taken by the therapist to reconnect. The therapist will repeatedly attempt to contact me through the remaining session time (and I will do the same as well). If necessary, email can be a backup to video and phone failure. The compromised appointment is subject to be billed at the full rate.

_____ I understand that I am responsible for payment for telehealth services and authorize my credit card to be charged at the time of session unless I previously arranged payment via cash or check.

SESSION RECORDINGS

I understand that my therapist will not record my in-person or telehealth sessions, unless there is an explicit written consent by me (below) for reasons that clearly benefit my treatment. In addition, I agree not to record sessions using audio and/or visual means.

If my counselor is an intern or staff member pursuing licensure, recordings can be used for consultation with the aforementioned supervisors for my enhanced care, as well as their professional growth. Please note: should you consent to audio and/or video recordings, such recordings will be kept in your client file and subject to release if requested by one of the means outlined herein.

I give my consent to audio and/or video recordings. YES NO _____(initial)

DISPUTE PROCESS

I agree that any dispute with Revision arising from or related to this agreement shall be settled through legally binding arbitration. I understand that this shall be the sole remedy for any controversy or claim arising out of this agreement and expressly waive my right to file a lawsuit in any civil court against Revision or any staff member of Revision for such disputes, except as necessary to enforce an arbitration decision.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

I have read and initialed all five pages of this Informed Consent and had sufficient time to be sure that I considered it carefully, asked any questions I needed to, and understand it.

_____	_____	_____/_____/_____
Client #1 Name	Client #1 Signature	Date
_____	_____	_____/_____/_____
Client #2 Name	Client #2 Signature	Date

If client is under 18 or under guardianship:

_____	_____	_____/_____/_____
Parent/Guardian #1 Name	Parent/Guardian Signature	Date
_____	_____	_____/_____/_____
Parent/Guardian #2 Name	Parent/Guardian Signature	Date

FOR OFFICE USE ONLY

Reviewed by:_____ Assigned Client # _____

INFORMED CONSENT FOR THE PRESENCE OF TOUCH IN PLAY THERAPY

Touch is a normal, healthy part of parent-child interaction. Research shows that healthy physical contact has an impact on the health of people of all ages. Physical touch is beneficial for many reasons as it can relieve stress, decrease anxiety, and increase comfort (Barnard & Brazelton, 1990, Field, 1993). Withholding touch because of fear of inappropriate touch can be as damaging to a growing child as inappropriate touch (Harlow, 1958). It is important that kids experience gentle, kind, loving, and safe touch.

When appropriate, and according to the therapist's clinical judgment, your child's therapist may utilize touch during play therapy session, drawing from several play therapy techniques outlined below. The therapist will attune to the child's reaction to touch and adjust the use of touch if the child is anxious or aversive to touch. If a child resists being touched, the therapist will find another way of providing a nurturing, calming experience.

Various kinds of touch can be essential for effective play therapy:

- **Structuring touch** may involve coordinated movements, touch, and sensory play. Activities may include (but are not limited to) popping bubbles or feeling the touch of a feather or cotton ball. During challenging activities, the therapist may provide physical assistance or guidance to help the activity be successful.
- **Engaging touch** is used as an important tool in creating relationships and communicating safety, acceptance, playfulness, and empathy. Activities may include (but are not limited to) clapping games or making a hand stack.
- **Nurturing touch** is important in building skills that allow the child the ability to eventually self-regulate. Activities may include (but are not limited to) feeding, taking care of hurts, cuddling and rocking. Noticing child's scratches/bruises and taking care of them with lotion or band-aids, feeding, singing to child, and putting arms around a child and rocking them supports a child through co-regulation.
- **Calming touch** may be used to support the child when dysregulated and may involve holding child on the lap of adult involving close physical contact.

I consent to the use of therapeutic touch during my child's play therapy sessions. If I have any concerns, I will make them known as they arise.

Minor Client Name: _____

Parent/Guardian Signed: _____ Date: _____

Parent/Guardian Signed: _____ Date: _____

Barnard, K.E., & Brazelton, T.B. (Eds.) Touch: The foundation of experience. Madison, CT: International Universities Press Inc., 1990.

Field, T.M. The therapeutic effect of touch. In G. Branningan &M. Merrens (Eds.), The undaunted psychologists: Adventures in research (pp. 3-12). New York: McGraw Hill, Inc., 1993.