Anita H. Pringle, LPC-MHSP, CSAT

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Franklin, TN 37064
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Counseling Policies and Processes:

Entering into a therapeutic relationship with a counseling professional requires an establishment of trust. When you begin therapy, you are committing your time, money and emotional energy and it is important to fully understand what that commitment will entail. Included below is a summary of the policies and processes that guide the work of this counseling practice and your work with me as your therapist.

1. **PROFESSIONAL BACKGROUND:** I hold a Master's degree in Counseling from Trevecca Nazarene University and am licensed as a Licensed Professional Counselor by the Tennessee Board for Professional Counselors. This allows me to practice as a therapist in the State of Tennessee.

2. **APPOINTMENTS:** You can make an appointment by calling or texting 615.696.9346. If I am unavailable to take your call, please leave a confidential message so that I can return your call within 24 hours. Since clients are seen by appointment only, unless an emergency requires an immediate appointment, this appointment time is reserved only for you. If it is necessary for you to cancel an appointment, notice of cancellation must be made at least 24 hours prior to your scheduled appointment time or you will be charged the set appointment fee. If you are experiencing a mental health emergency and cannot reach me, please go directly to your nearest emergency room for assistance or call the Crisis Help Line at 615-244-7444.

3. **FEES AND PAYMENTS FOR COUNSELING SERVICES:** Fees for counseling services are $95 for 45-50 minute sessions with individuals and couples. Should this rate be a financial burden, please discuss it with me further. I reserve a limited number of reduced fee sessions for those who may be experiencing great financial need.

4. **CONFIDENTIALITY:** Tennessee State law and ethical requirements of the State Board indicate that what we discuss in our private counseling sessions is privileged communication, meaning that you as the client control the release of this information to a third party. There are several limits to confidentiality that involve the required release of information in order to keep you and/or others safe from harm. These limits include: clear and imminent danger to self or others; suspected child or elder abuse; a direct court order by a judge ordering me to release records or appear in court to testify. If it would benefit you in your

counseling progress, I may ask you to sign a release of information to allow me to discuss information with your primary heathcare professional or other key providers in your life.

5. **HIPAA NOTICE OF PRIVACY PRACTICES:** Included with this initial introductory paperwork, you should have received a copy of the HIPAA document. I am required by law to provide this to you and to secure your signature. If you should have any questions about this document, please do not hesitate to ask me for clarification.

6. **BENEFITS AND RISKS OF COUNSELING:** Counseling can be of great benefit to a client who fully commits to being open and honest in the counseling relationship. It requires the client to come to the table with their own personal goals for counseling. I cannot create change in your life; you are the change agent in your own life. I cannot guarantee a specific outcome from our time together. Clients are ultimately responsible for their own growth and direction in counseling. During our counseling sessions, we may discuss additional resources or activities that added to counseling may help further your change and growth. These may include referrals to a Primary Care Provider for medication evaluation, directions for a specific activity plan of exercise, referrals to a nutritionist, etc. Wellness comes from whole body health that should include an emphasis on mind, body and spirit. After we have met to discuss your concerns, we will create a plan that is individualized to your own goals and desires for counseling outcomes.

Please feel free to discuss with me any of the policies and processes outlined above. It is important that you clearly understand your rights and responsibilities when entering into a counseling relationship.

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Instructions: Your personal information and signed consent to begin therapy is required and it is important to have this information on file. Please fill out the necessary information and sign prior to beginning any therapy.

Initial Therapy Intake Form

Client Information:

Client's Name_____
Client's Age_____ Client's Date of Birth_____
Client's Social Security Number_____
Address_____
Preferred Phone Number_____
Email Address_____
Occupation_____ Employer_____
Religious Preference (if any) _____
If client is a minor, name of responsible adult (guardian) _____
Emergency Contact person: _____Phone: _____

Medical/Mental Health History:

Any Previous Therapy/Counseling: _____
If yes, what type of therapy and how long did you attend? _____
_____
Was therapy beneficial to you? Why did you feel it helped/didn't help? _____
_____
_____
Are you currently in treatment with any other counselor or psychiatric provider? _____
Medical Problems (describe):_____
History of any hospitalizations (medical and/or psychiatric):_____
_____
Name of Primary Care Physician:_____Phone:_____
Name of Psychiatrist (if applicable): _____Phone: _____

Therapy Goals and Client Stressors

What do you wish to achieve through therapy at this time?_____
_____
_____
_____
_____
Briefly describe the history of this problem. _____
_____
_____
_____
_____
Currently, and during the last two years, what are/have been some of the stressful events in your life (death of a loved one, loss of a relationship, job loss, family difficulties, disappointments, etc)? _____
_____
_____
_____
Do you have a trauma or abuse history (victim of or witness to physical or sexual abuse, domestic violence, traumatic losses, etc). If yes, please describe: _____
_____
_____
_____
_____

Your Relationships

___Single ___Married ___Divorced ___Remarried ___Separated
___Widowed ___Engaged ___Living Together

Spouse's/Partner's name (if this applies): _____
Length of time together:_____
Your children's names and ages (if applicable): _____
Who currently lives in your home: _____
Please identify any areas of conflict or trauma that you have experienced in your relationships (ie: adultery/affairs, financial problems, sexual addiction, alcohol and/or drug addictions, domestic violence, etc):
_____
_____
_____

Your Substance Use/Addiction History

Prescription Drug Use (Current names and doses): _____
_____
Previous Prescription Drug Use (names and doses): _____
_____

Any side effects?_____
History of Illegal Drug use? (describe):_____
Current Illegal Drug use? _____
Alcohol use/abuse (describe frequency and reason for use):_____
_____
Do you struggle with other addictive behaviors (overeating, constantly working, extreme shopping binges, gambling, sexual acting out, etc)? If yes, please describe. _____
_____

Your Spirituality

What (if any) was your spiritual upbringing? _____
What (if any) is your current spiritual orientation? _____
Check all phrases that describe your current religious experience:

___Atheist	___Agnostic	___Curious
___Seeking God	___Spiritual…not religious	___Strong Faith
___Pray often	___Skeptical	___Closed towards God
___Open towards God	___God is distant	___God loves me
___God is good	___God is cruel	___Communal Worship
___Stagnant	___Charismatic	___Fearful of God

Symptom Assessment:

Check all of the following that apply to you:

Emotional Symptoms-

__ anger	__ anxiety	__ extreme mood shifts
__ irritability	__ worrying	__ frustration
__ hopelessness	__ helplessness	__ fears
__ depression	__ apathy	__ lack of emotions
__ feelings of inferiority	__ panicky	__ unable to have a good time
__ guilt	__ feelings of worthlessness	

__ other (specify) _____

Cognitive Symptoms-

__ problems with concentration	__ inattention
__ difficulty making decisions	__ distractibility
__ racing thoughts	__ memory problems
__ repeated unwanted thoughts	__ hallucinations
__ recurring nightmares	__ other _____

Physical Symptoms-

__ increase or decrease in appetite	__ shaky hands/feet
__ tearfulness/crying spells	__ racing heart rate
__ sweating/chills	__ body pain/numbness
__ stomach or intestinal distress	__ frequent or severe headaches
__ sleep difficulties	__ muscle tension
__ dizziness/fainting	__ other _____

Behavioral Symptoms-

__ hyperactivity
__ suicidal gesture/attempt history
__ present suicidal thoughts
__ verbal aggression
__ social withdrawal
__ self-injury
__ disorganization
__ lying/deceitfulness
__ financial problems
__ other_____

__ impulsivity
__ binge eating/overeating
__ relationship problems
__ physical aggression
__ induced vomiting
__ increased alcohol/drug use
__ oppositional/defiant
__ sexual problems
__ avoidance of school or job

Upon my signature below, I hereby attest that all the information furnished is true and correct.

_____ _____
Client Signature (if completed by client) **Date**

_____ _____
Signature of Legal Guardian of Client under the age of 16 **Date**

_____ _____
Counselor Signature (if completed by counselor) **Date**

Anita H. Pringle, LPC-MHSP, CSAT
HIPAA Privacy Practices

I am required by law to follow the practices described in this letter. This letter is a summary of my Privacy Practices. This notice applies to personal medical/mental health information that I have about you, and which are kept in or by this facility. With some exceptions, I must obtain your authorization to disclose (or release) your health care information. There are some situations in which I do not have to obtain your authorization. I can use your protected health care information and share it with members of our organized health care arrangement (like a community provider.) This Notice of Privacy Practices does not cover every possible use or disclosure. If you have any questions, please contact Anita Pringle.

Who Has Access to Your Personal Information?

Medical/Mental health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals who work at this facility and are involved in your care or treatment. It may also include provider agencies whom we pay to provide services to you. We will release as little information as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third party payers.
- Obtain approval, in advance, from your insurance company.
- Exchange information with Social Security, Employment Security, or Social Services.
- Measure our quality of services.
- Decide if we should offer more or fewer services to clients.

Without your permission, we may use your personal information:

- To exchange information with other State agencies as required by law.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To inform you about possible treatment options.
- To send you appointment reminders.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal, or local law. This includes investigations, audits, inspections and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroner, medical examiners and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

What Are Your Rights?

- To see and get a copy of your record (with some exceptions.)
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete.
- You must make this request in writing. We may deny your request if:
    1. We did not create the entry.
    2. The information is not part of the file we keep; or
    3. The information is not part of the file that we would let you see; or
    4. We believe the record is accurate and complete.
- To know to whom we have sent information about you for up to the last six years.
- To request your medical/mental health information. The first request in a 12 month period is free. We may charge you for additional requests.
- To limit how we use or disclose information about you. For example – not to release information to your spouse or a particular provider agency. This must be made in writing, and we are not required to agree to the request.
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To authorize other release of your personal information not described above. You may change your mind and remove the authorization at any time (in writing.)

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HIPAA NOTICE OF PRIVACY PRACTICES
AND
COUNSELING POLICIES AND PROCESSES
ACKNOWLEDGEMENT

Please read and initial next to each item and sign the form below.

_____I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices. I understand that after I have read the notice I may address any questions to my therapist.

_____ I acknowledge that I have received a copy of the Counseling Policies and Processes. By signing below, I acknowledge having read, understood, and agreed to these policies and processes, including the financial agreement, and issues of confidentiality.

_____ I give consent to contact my identified emergency contact in the event of a psychiatric emergency situation.

_____ I give consent to my therapist, Anita H. Pringle, to provide clinical treatment in the context of the counseling relationship.

_____ _____
Client Signature **Date**

_____ _____
Client Signature **Date**

_____ _____
Signature of Legal Guardian of Client under the age of 16 **Date**

_____ _____
Therapist **Date**

Revised 10/2017