Transformational Counseling
Dr. Judy Bruce, Ph.D. (Communication)
Licensed Professional Counselor
111Petrol Point, Suite B6
Peachtree City, Georgia 30269
State of Georgia LPC#011395
Ph: 720-254-3992

CLIENT INFORMED CONSENT AND DISCLOSURE STATEMENT AGREEMENT FOR SERVICES

As we begin our counseling relationship, it is important that you understand the services I offer, my approach to the counseling relationship, risks and benefits of our work together, your rights as a client, and standard office policies and procedures. Please read this information carefully and let me know if there is any part you do not understand. As I share my skills and expertise to support your goals for change, I understand that I am merely a resource for you as you take responsibility for your growth and well-being.

Therapy Services Offered
In your pursuit of integration and growth, I offer a Christian based psychotherapy to support healing, personal balance, relationship stability and health, and to promote positive change. In addition to this traditional client-centered therapy, I offer a biblically based protocol for energy psychology called Splankna Therapy. This method incorporates several newly-emerging energy-based techniques. You have the option of using any of the approaches I offer in our work together.

Theoretical Approach
Energy Techniques is a collective term used to refer to a variety of methods based on the use, modification, and manipulation of energy fields that look at imbalances within the person's energy system as well as the energetic influence of thoughts, beliefs, and emotions on the body. The prevailing premise of the Energy Techniques is that the flow and balance of the body's electromagnetic and more subtle energies are important for physical, spiritual, and emotional health, and for fostering well-being. The Splankna method (hereafter the Method) is designed to help get to the origin of an emotional issue with the goal of rapidly desensitizing the emotional stress and restoring proper energy flow. Basic biblical principles, such as confession, repentance and forgiveness, and prayer are essential elements of the Method.

Although Energy Techniques like Splankna Therapy appear to have promising emotional, spiritual, and physical health benefits, they have yet to be fully researched by the Western academic, medical, and psychological communities and, therefore, may be considered experimental. The Energy Techniques are self-regulated and they are considered alternative or complementary to the

healing arts that are licensed in the State of Colorado. Because Energy Techniques are relatively new healing approaches, the extent of their effectiveness, as well as their risks and benefits, are not fully known. If you ever have questions or concerns about the nature of the theories, methods, approaches and/or techniques I use, please feel free to ask me for further resources or references.

Outcome Expectations; Risk & Benefits; Treatment Plan
Please note that it is impossible to guarantee any specific results regarding your goals using any of the approaches I offer in my practice, and we don't know how you will personally respond to any of the approaches. However, we will work together to achieve the best possible results for you. Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy, but working toward these benefits requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. You will have to work both in and out of the counseling sessions. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation.

As with any intervention, there are risks associated with counseling and therapy. Risks during evaluation or therapy might include remembering, talking about, or experiencing unpleasant events which results in uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, worry, etc., or experiencing depression or insomnia, or difficulties with other people. Being confronted with your difficulties can be very challenging. Some changes may lead to what seems to be worsening circumstances or even losses (for example, counseling cannot necessarily keep a marriage intact).

In addition, if you choose to use the Energy Techniques or Method as part of our work together, emotional or physical sensations or additional unresolved memories may surface which could be perceived as negative side effects. With the Energy Techniques or Method it is possible to experience some emotional distress and physical discomfort related to previous life experiences. Please be advised that if we utilize the Energy Techniques or Method it is possible that previously vivid or traumatic memories may fade. While this is a positive outcome, it could adversely impact your ability to provide legal testimony that carries the same emotional impact as prior to applying the Energy Techniques or Method regarding a traumatic incident.

If we are to work together we will need to specify methods, risks and benefits of treatments, the approximate time commitment involved, costs and other aspects of your particular situation. We will discuss a plan that seems most appropriate to help you reach your goals. Periodically, we will evaluate your

progress and if necessary redesign our treatment plan, your goals, and the methods used. However, regardless of our work together, you agree to take full responsibility for your self-care in the emotional, mental, physical, and spiritual dimensions of your life.

Other Important Information
Please be advised the approaches I offer are not intended to be a substitute for medical diagnosis or treatment, and they do not replace the services of a licensed physician. You agree and understand it is your responsibility to consult with your physician for any specific medical problems. Further, you understand I may suggest you contact your physician if I believe it is advisable. In addition, you understand that any information shared during our sessions is not to be considered a recommendation that you stop seeing your physician or using prescribed medication without consulting with your physician, even if after a session it appears and indicates that such medication or treatment may be unnecessary.

Use of Touch
You understand the application and teaching of the Energy Techniques and Method may include light touch. Touch can be a potential problem in a healing relationship if you have had a history of paranoia, have been diagnosed with borderline personality disorder, have been sexually or physically abused, or have suffered from other types of trauma. Please let me know if you fall into any of these categories prior to our starting our work together. We can discuss any emotional risks associated with touch that may be of concern to you. **Furthermore, if you have any misgivings, doubts, or any negative reactions to any physical contact, it is very important that you let me know as soon as possible so that we can discuss your concerns.** You understand you have a choice about these techniques that involve touch.

Education and Training
Degrees:

Bachelor of Arts BA in English Literature, Mary Washington College
Master of Arts MA in Philosophy, Colorado State University
Master of Arts MA in Biblical Counseling, Colorado Christian University
Doctor of Philosophy PhD in Human Communication, University of Denver

Work Experience:

Psychotherapist in Private Practice 1995 to present
EMDR Training 2017
Certified Master Level Splankna Practitioner 2011
Instructor of Speech at University of Denver 2001 to 2004
Intern for City of Denver Board of Ethics 2002
Instructor of Philosophy Colorado State University1988-2001

Acknowledgment and Consent to Receive Services

By signing this document and any attachments hereto, you agree that I have disclosed to you sufficient information to enable you to decide to undergo or forgo any of the approaches and other services I offer. You understand that you are freely choosing to take advantage of my services and would otherwise have the option of using conventional health care services exclusively, provided by another professional health care provider of your choosing. You understand that your consent to the nature of our sessions is given voluntarily, without coercion, and may be withdrawn at any time in the future. Further you understand if you choose to use the Energy Techniques or Method as part of our work together, that they are a relatively new healing approaches and the extent of their effectiveness, as well as their risks and benefits are not fully known, and you agree to assume and accept full responsibility for any and all risks associated with using the Energy Techniques or Method as part of our work together. You represent that you are competent and able to understand the nature and consequences of our proposed sessions and agree to be personally responsible for the fees related thereto. You have read and understand the above disclosure about the services offered by me and my training and education and you have discussed with me the nature of the services to be provided.

By signing in the space provided below, you knowingly, voluntarily, and intelligently assume these risks and, except in the case of gross negligence or malpractice, agree to release, indemnify, hold harmless and defend Dr. Judy Bruce, Ltd., its owner, employees, representatives, and consultants from and against any and all claims or liability, of whatsoever kind or nature, which you or your representatives may have for any loss, damage, or injury, including without limitation, physical, emotional, mental, financial, or personal, arising out of or in connection with your sessions.

Your acknowledge that we have discussed and you understand, agree and have received a copy of my **Additional Client Information & Office Policies & Procedures** required under Colorado Laws governing Licensed Professional Counselors which is attached hereto and incorporated herein by reference. Please sign both copies of these forms for my confidential records and retain a copy for your records.

_____ _____

Client Signature Date

_____ _____

Therapist Signature, Dr. Judy Bruce, PhD

Date

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Additional Client Information &
Office Policies and Procedures

Clients Rights

1. The practice of psychotherapy by both licensed and unlicensed persons is regulated by the Department of Regulatory Agencies. Any questions, concerns or complaints regarding the practice of psychotherapy or any other mental health profession may be directed to:

State of Georgia
Board of Professional Counseling
237 Coliseum Drive, Macon GA 31217

2. You are entitled to receive information from me about the methods of therapy, the techniques used, the duration of therapy (whenever possible), and the fee structure. By signing this document you acknowledge that I have provided you with this information.
3. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time. I ask that you schedule a final short session for termination rather than doing so by phone or letter only. This session (free) can be very helpful for us both in achieving closure in our work together.
4. In a professional relationship, sexual intimacy is never appropriate and should be reported to the State Grievance Board.
5. REGARDING CONFIDENTIALITY: As a licensed professional counselor, there is a legal privilege in this state protecting the confidentiality of the information that you share with me. What this means is that for whatever reason I was subpoenaed into court to testify regarding a matter for which you would be before the court, I could not be compelled to testify against your wishes. As a professional, I can assure you that I strive to maintain the strictest ethical standards of confidentiality.

There are LEGAL EXCEPTIONS TO CONFIDENTIALITY: You may request that I disclose information to a third party by signing a release for me to do so. Additionally: Situations in which you are at serious risk to harm either yourself or others, such as in the cases of potential suicide, child abuse and neglect, or grave disability allow for exception of confidentiality. You should also be aware that social service agencies define a broad range of events as reportable under child protection statutes, including various types of hitting which could not be construed as acceptable discipline, whether or not bruises are made. Legal

confidentiality does **not** apply in a criminal or delinquency proceedings, or if the client brings a suit against the therapist.

Further, there are times in which child abuse which occurred quite some time ago may be legally required to be reported, usually when the victim of past abuse is still under the age of 18.

As we work together, any exceptions to confidentiality will be identified as they arise.

In summary, (a) I am required to initiate a mental health evaluation of a client who is imminently dangerous to self or to others, or who is gravely disabled as a result of a mental disorder; (b) I am required to report any suspected incident of child abuse or neglect to law enforcement; (c) I am required to report any threat of imminent physical harm by a client to law enforcement and to the person(s) threatened; (d) I am required to report any suspected threat to national security to federal offices.

In compliance with **HIPAA** regulations, your psychotherapy notes will NOT be disclosed electronically or otherwise to any third party without your consent, other than in the above noted exceptions.

COUPLES COUNSELING AND CONFIDENTIALITY: The legal standing of privileged communication is less clear in marital and family work where there are multiple clients.

Information given to me in individual sessions will be held in confidence, unless I believe that withholding that information will be harmful to the other partner or to the couples' alliance. You understand that by signing this document you agree that in such cases, I may inform the other partner of that essential information.

6. While I make every effort to be available to any client who wants to schedule additional sessions during a crisis, I am not available after business hours or for emergency care. If you anticipate that you may need this kind of care, I recommend that you seek another therapist or mental health professional who offers what you need.

7. I also consult with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas as to how to best help you reach your goals. Such consultations are obtained in a way that complete confidentiality is maintained (except in cases that you waive this right to confidentiality).

Explanation of Dual Relationships

We will form a close professional relationship during our work, and you will become exceedingly important to me as my client. It is important to know that our relationship is a therapist/client one and there can be no other other relationship during this time, such as your being my plumber or lawyer; dual relationships are not ethical as long as we have this professional one. If we encounter each other in a social setting, I will take my cue from you whether you wish to acknowledge knowing me and wish to greet me. In any case, I will always maintain your confidentiality.

Agreement to Pay for Professional Services

I agree to pay Dr. Judy Bruce her fee of $150 per single 50 minute session and $225 for a session and a half (75 minutes). Phone sessions and case management will be billed at the same rate. *I also agree to pay $25 for a returned check.* If you need to cancel an appointment, please give me 48-hour notice by *phone* or *voicemail* (email is not timely). *I agree to pay the full fee for a session cancelled with less than 48-hour notice.* This policy is in place to ensure a schedule that allows for clients to access slots that have opened up when emergencies arise.

You may call 720-254-3992 regarding any questions you may have, and I will get back to you at my earliest availability. Please note that I use a cell phone for my main means of connection. Cell phones do not guarantee confidentiality. By signing this form you are allowing me to use my cell phone for our out of office communications. You may also contact me via email. Again, please note that email does not guarantee confidentiality. By signing this form you are allowing me to use email for our out of office communications.

Emergency office or phone sessions (full or reduced time) can be scheduled during the regular work week (9-6 Monday – Thursday) and paid for on a prorated basis. Any paperwork or extensive reading at your request will also be charged on a prorated basis.
There are times that a short check-in with me may help in your work, and I welcome the chance to support you. 10-minute phone consultations are not charged to you.

In order to ease the stress of remembering to bring payment please include your credit card information below. If you forget payment or cancel within 48 hours your card will be charged. All information is securely stored.

Circle card type: Visa MasterCard Discover

CVV (3 digits on the back of the card)_____ Billing Zip Code_____

Card Number_____ Expiration_____

_____ _____
Client Signature Date

_____ _____
Therapist's Signature, Dr. Judy Bruce Date

Confidential Client Information

Personal History: Date:____/____/___

Last Name_____First Name_____Initial___
Address_____City_____State___Zip__
Email_____Home Phone _____
Work or Cell #_____May I contact you at home?___at work?____
Birthdate ___/___/___ Age ___ Gender: Male___ Female___
Occupation_____ Highest level formal education_____
Marital Status:
Single___Married___Widowed___Divorced___Separated___ If married, how long? _____Spouse's Name_____
Is your spouse supportive of your seeking counseling?_____
Do you have children?_____ Names & Ages _____
_____
In case of emergency, please notify _____@_____
Referred By_____
Do I have your permission to thank the person who referred you? Y N If so, please sign here to acknowledge your permission to do so _____

Medical:
Are you currently under medical care?_____If yes, please indicate reason ____
_____
Physician's
name_____Phone_____
Do you take prescription medications? ___ If yes, what are they?
_____
_____
Prescribing physician's name, if different from above _____Phone_____
List any psychiatric/mental health medications you have taken _____
_____
Date and outcome of last physical exam _____
Other significant medical history _____
_____

Counseling History:
Have you previously seen a counselor/psychologist/psychiatrist?_____
Name/Dates/Location _____
When was your last appointment with any of the above? _____
Reason for terminating last counseling _____
Have you ever been admitted to a mental health care facility? _____
If so, date and location _____
Have you ever attempted suicide?____Have any family members or close friends attempted suicide? _____

State the reason you are seeking counseling at this time: _____
_____
_____
How do you hope counseling will help? _____
Is there anything else that you feel is important for your counselor to know initially? _____
_____

Please circle any of the following struggles that pertain to you:

Nervousness Health Problems Unhappiness Alcohol Use

Honesty Sexual Problems Suicidal Thoughts Divorce

Compulsive Habits Financial Struggles Ambition Loneliness

Concentration Abortion Anger Self-Control

Temper Memory Stress Parents

Career Choices Drug Use Decision-Making Children

Eating Disorders Tiredness Depression Impulsiveness

Education Grief/Loss Appetite Marriage

Doubts about God Intimacy Relationships Separation

Inferiority Feelings Shyness Sleep Problems Friends

Thought Patterns Nightmares Addictions Fears

Briefly Describe your Childhood Family:

_____
_____
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_____
_____