Personal Information Form

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last Name, First Name Initial)

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to Leave Messages at Which of the Above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT EMERGENCY INFO:**

Person to Contact in Case of Emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOCTOR INFO:

Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONFIDENTIALITY POLICY

Content of all our therapy sessions are considered to be confidential. Both verbal

information and written records about you cannot and will not be shared with another party

without your written consent. Noted exceptions of this policy are as follows:

**Suicide/Homicide**

If during our work together you disclose active intentions or a plan to harm another person, I will need to warn the intended victim and report this information to legal authorities.

In addition, if you disclose or implies a plan for suicide, I am required to notify legal authorities and make reasonable attempts to notify your emergency contact.

**Abuse of Children and Vulnerable Adults**

If during our work together you state or suggest that you are abusing a child (or vulnerable adult) or have recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, I am required to report this information to the appropriate

social service and/or legal authorities.

**Malpractice or Lawsuit**

If you were to file a lawsuit or complaint with my licensing board, I have a right to release pertinent treatment information for my defense.

**Legal**

Information may have to be released in response to a subpoena from a court. If records are subpoenaed I will take all efforts to squash the subpoena prior to release of your personal information.

**\*\*Information that may be requested in any of the above limits includes: type of services,**

**dates/times of services, diagnosis, treatment plan, and description of impairment, progress**

**of therapy, case notes, and summaries.**

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Signature Date

 Treatment Policies and Consent for Treatment

**CLIENT/THERAPIST RELATIONSHIP**: You and I will have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I will be able to best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

**RISKS AND BENEFITS**: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, reduction of symptoms that brought you to therapy and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

**PARAMETERS OF COUNSELING SERVICES**: I provide short-term intensive counseling for individuals who feel they are limited in their current life. During this type of counseling we will choose a problem or two that is limiting your life and we will focus on identifying and resolving past issues that could be contributing to these problems. We will not have an ongoing traditional therapeutic relationship. I do offer 1-2 pre and post telehealth sessions (at an additional cost and according to your state’s regulations) if requested. In addition, you are welcome to book as many follow-up intensive sessions as needed. If you discover you would like to establish an ongoing therapeutic relationship, I will assist you with identifying several resources for this service near your area.

**THERAPY/OUTCOMES OF THERAPY/REFUNDS:** My goal is to provide the most effective therapeutic experience available to you. My primary treatment approaches are **E**ye **M**ovement **D**esensitization **R**eprocessing and Ego State Therapy. These therapies are designed to get to the root of many of your issues. In my experiences these two therapies in combination can reduce most trauma symptoms. During our time together, I make the commitment to provide you with my full attention, clinical skills and 10+years of clinical experience. While I am certain you will experience symptom relief from our work together I cannot guarantee any treatment outcomes. I will not be able to offer refunds for a lack of specific treatment outcomes. I can only offer refunds if due to unforeseen circumstances I have to cancel a session or a portion of our sessions.

**APPOINTMENTS**: Appointments are typically scheduled on a daily basis with each day being 6 hours in length. The minimum amount of time available is 6 hours and the maximum amount of time available is 18 hours (3 days). At this time, I only offer sessions on Friday, Saturday and Sundays. Below is a typical daily schedule (flexible to meet your needs):

|  |  |
| --- | --- |
| **Time** | **Activity** |
| 9:00-10:30AM | Therapy |
| 10:30-10:45AM | Break |
| 10:45-12:00PM | Therapy |
| 12:00-1:30PM | Lunch |
| 1:30-3:00PM | Therapy |
| 3:00-3:15PM | Break |
| 3:15-4:30 | Therapy |

**PHONE POLICY:** If for some reason you need to reach me outside of our scheduled time for the intensive therapy, you can reach me at (912) 403-8659.

**CONSENT TO TREATMENT**: By signing this Treatment Policies and Consent Form, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving therapy in an intensive format from Laura Mullis, LCSW.

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Signature Date

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Triumph Center Date