Bonny Parkhurst, LPC, PLLC
2121 S. Columbia Ave., Suite 309
Tulsa, OK 74114
918-292-9432
www.TulsaFamilyCounselor.com
BonnyParkhurstLPC@gmail.com

Welcome!

I would like to welcome you to my private counseling practice. For the purpose of keeping you informed as you enter into therapy, I am providing you with my statement of professional disclosure.

My name is Bonny Parkhurst and I am a Licensed Professional Counselor in the state of Oklahoma, License No. 5006, and a National Board Certified Counselor with the National Board for Certified Counselors, No. 335001. I received my Master's in Community Counseling from Oklahoma State University and before that my undergraduate degree at the University of Oklahoma.

I have additional education and training in Cognitive Behavioral Therapy, Trauma-focused Cognitive Behavioral Therapy, Narrative Therapy, Family Systems Therapy, Play Therapy, Dialectical Behavior Therapy, Solution-focused Therapy, Acceptance and Commitment Therapy, and crisis intervention. I am also a current member of the American Counseling Association, Member No. 6295224.

The following is the contact information for the Oklahoma State Board of Behavioral Health:

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Suite 110
Oklahoma City, OK 73118
Phone: (405) 522-3696
Fax: (405) 522-3691

If you would like to discuss my credentials further, please feel free to contact me.

Thank you,

Bonny Parkhurst, MS, LPC, NCC

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Informed Consent for Counseling Services

CONFIDENTIALITY: Everything you say in our sessions and the written notes I take are confidential and may not be released to anyone without your written permission except when disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED BY LAW:

1. Child abuse or elder abuse is disclosed.
2. Client presents a danger to self and refuses appropriate care.
3. Client threatens to harm someone else or poses a threat to the safety of others.
4. Legally ordered by a court of law.

ADDITIONAL REASONS FOR DISCLOSURE:

1. When case consultation is presented in an anonymous manner to other professionals.
2. To collect a debt for services rendered.

FEE FOR SERVICES: My fee for services is $100.00 for a 50 minute session and $150.00 for a 90 minute session. Payment is expected on the date service is provided. I accept payment for services in the form of cash, check, money order, or credit card. There will be a $25.00 charge for returned checks.

APPOINTMENTS/SCHEDULING: If you must cancel an appointment, **you are obligated to cancel within 24 hours of your scheduled appointment time.** However, please call my office at (918) 292-9432 as soon as you are aware you will be unable to attend so that your time may be offered to another client. If the office is closed or I am unable to answer the phone when you call, you **MUST** leave a voicemail message indicating you are cancelling the appointment along with the reason for cancelling. If you cancel or need to reschedule with less than 24 hours notice, you will be charged a fee of $50.00 for the missed session. Late cancellation/no-show fees that are incurred must be paid before appointments can be rescheduled.

EMERGENCY: If there is an emergency during therapy or after therapy and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided as an emergency contact.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call me at (918) 292-9432. Please do not email me as I do not check emails on a daily basis and email is only to be used for scheduling sessions. Please do not text me as I do not respond to text messages. If I do not answer my phone, I will return your call within my scheduled business hours. If you believe your call to me may take more than 15 minutes, please schedule an appointment so we can address the presenting issue. If an emergency situation arises, indicate it clearly in your message. If you are experiencing a mental health emergency, call 911 or go to your nearest emergency room.

EMAIL POLICY: Email correspondence is to be used for appointment scheduling *only* (not to cancel your appointment – a cancellation should be conveyed via telephone as stated above). Due to the unsecured nature of electronic communication, confidentiality breaches can occur and by signing this form you are stating that you understand a confidentiality breach could occur if you choose to utilize

email for scheduling or other correspondence and that I am not liable if such a breach occurs.

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires I keep treatment records for at least 6 years beyond termination of services. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your written request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment.

COURT RELATED SERVICES: If phone consultation with your attorney is requested or I am asked to write any type of report, such as an explanation summary of counseling, you will be charged at the rate of $100.00 per hour, with a quarter hour minimum charge. These fees will be documented and recorded in your file and you will agree to pay upon receipt of a bill. The hourly fees for court/deposition testimony are the same as my therapy session fees and are calculated on door to door time. An eight hour minimum charge must be paid in advance. Costs include testimony, consulting, or waiting to be called. I do not perform child custody evaluations or forensic assessments. There will be a copy fee for a copy of your file, if requested or subpoenaed, of not less than $50.00 paid in advance. Clients must sign a Release of Information form allowing me to openly communicate with all parties related to the lawsuit. For the safety and professionalism of the counseling process, no exceptions will be given. A subpoena must be issued before I can make a court appearance, deposition appearance, or deliver records. The party issuing the subpoena will be financially responsible for all related fees (see above charges).

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: The therapeutic process is different for everyone. It is possible to resolve the issue that brought you into therapy, but it takes effort on your part. It is vital we engage in open and honest dialogue in order to build the foundation necessary to support the therapeutic process. It is likely we will have discussions that cause you discomfort and that I will ask you to challenge some of your ways of thinking to facilitate change. Change can sometimes be easy and swift, but it can also be slow and even frustrating at times. I utilize various psychological approaches and choose the approach I use based on the therapeutic issues presented. These approaches include: Family Systems, Behavioral, Cognitive-Behavioral, Trauma-Focused Cognitive Behavioral, Dialectical Behavior, Narrative, Psychodynamic, Existential, Solution-Focused, Acceptance and Commitment, and Psycho-Educational. I do not prescribe medications.

TERMINATION OF TREATMENT: After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that case, I will provide you with three referrals whom you can contact. If at any point during therapy you are non-compliant (consistently unable to keep scheduled appointments, unwilling to engage in the therapeutic process, or any other non-compliance with office policies) I will terminate treatment. In such a case, I will provide you with three referrals whom you can contact. Upon your request, and with your written consent, I will provide her/him with the essential information needed. You have the right to terminate therapy with me at any time.

I have read and understand the above policies.

Client's Signature (14 y.o. and up) _____ Date _____

Legal Guardian's Signature (for minor)_____Date_____

Therapist's Signature _____Date _____

Patient Health Information Consent Form

I 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 begin any health care operations I 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 policies and procedures concerning the privacy of your Patient Health Information I encourage you to read the HIPAA NOTICE that is available to you to review before signing this consent.

1. The patient understands and agrees to allow this office to use 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 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. Clinical records, psychotherapy notes, and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have the right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.
3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. Psychotherapy contact notes are not available for the patient to review. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. My office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
4. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect 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.
6. For your security and right to privacy, staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in the office. I 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 the privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. My office reserves the right to make changes to this notice and to make new notice provisions effective for all protected health information that it maintains. You will be provided with the new notice at your next visit following any change.
9. This notice is effective on the date stated below. You may revoke that permission in writing at any time.
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.

Patient signature (14 y.o. and up): _____Date:_____

Legal guardian signature for minor child:_____Date:_____

For further information regarding this notice, please contact Bonny Parkhurst at 918-292-9432.

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MINOR CHILD INFORMATION

Please complete the following information for the person seeking services.

Last Name:_____First Name:_____MI:_____

Other Names:_____Date of Birth:_____

SSN:_____ Insurance Provider/Member Number:_____

Address:_____City/State:_____Zip Code:_____

Child Lives With:_____School:_____

Mother's Name: Mother's Employer:

_____ _____

Address:_____ _____

Home #_____ Work #_____

Father's Name: Father's Employer:

_____ _____

Address:_____ _____

Home #_____ Work #_____

OTHER PLACEMENT:

Name:_____ Phone: _____

Address:_____

Relationship to Client:_____

Is child in DHS Custody or OJA? ____Yes____No

Case Worker:_____CW Phone #:_____

County of Jurisdiction:_____

Person Providing Information:_____Relationship to client:_____

Client signature (14 y.o. and up): _____Date:_____

Legal Guardian Signature: _____Date: _____

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Individual Intake

Questions should be answered for the individual seeking treatment. Please answer all questions below to the best of your ability. The information you provide will be helpful to me in identifying your specific needs/concerns as well as the therapeutic modalities to utilize in your therapeutic process.

Name:_____ Date:_____

Please tell me about the issue(s) that brought you in today (you may use the back of this page if you need additional space):

_____
_____
_____
_____
_____

Have you seen a therapist in the past? ( ) yes ( ) no

If yes, how long ago? _____

Have you ever been diagnosed with a mental health issue? ( ) yes ( ) no

If yes, what was your diagnosis? _____

Are you currently experiencing sadness? ( ) yes ( ) no

If yes, on a scale of 1-10 (1 being just a little sad and 10 being extremely sad) where are you on that scale? (please circle)

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing anxiety? ( ) yes ( ) no

If yes, on a scale of 1-10 (1 being a little anxious and 10 being extremely anxious) where are you on that scale? (please circle)

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing anger? ( ) yes ( ) no

If yes, on a scale of 1-10 (1 being just a little angry and 10 being extremely angry) where are you on that scale? (please circle)

1 2 3 4 5 6 7 8 9 10

Are you currently having thoughts of suicide or self-harm? ( ) yes ( ) no

Have you had thoughts of suicide in the past? ( ) yes ( ) no

If yes, how long ago? _____

How many alcoholic beverages do you drink in a week? _____

Are you currently taking medication for pain management? ( ) yes ( ) no

Are you currently using any other substances? ( ) yes ( ) no

If yes, please describe (substance used, how often, how long): _____

_____

Are you currently prescribed medication by a physician? ( ) yes ( ) no

If yes, please describe (prescription, how often, how long): _____

_____

Who would you consider to be your support system? Please list each individual's name and relationship to you:

_____

_____

_____

What would you consider to be the most important piece of information for me to know about you?

_____

_____

_____

_____

Client Signature (14 y.o. and up): _____

Date:_____

Legal Guardian Signature (for minor clients): _____

Date: _____

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FINANCIAL POLICY AND MISSED APPOINTMENT POLICY

Please read over my financial and missed appointment policy. If you have questions about this policy, please feel free to discuss with me.

FINANCIAL POLICY:

Fees. Counseling sessions are 50 minutes or 90 minutes long. The fee for a 50 minute session is $100.00 and the fee for a 90 minute session is $150.00. Payment is collected at the first of the session. I also ask you to place a credit card on file for any future billing.

Insurance Clients. If you have health insurance, I am happy to call your insurance company and verify your insurance benefits. If your insurance covers a portion of your therapy I will be happy to wait for 30 days for your insurance to pay their portion. However, you will be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

Self-Pay Clients. Patients without insurance or with unmet deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

Methods of Payment. I accept cash, checks, and major credit cards.

MISSED APPOINTMENT POLICY:

Twenty-four hour notice is required for the cancellation of an appointment. Appointments canceled with less than a 24 hour notice will be charged $50.00. Appointments missed because of inclement weather will not be charged. Your charge will be applied to your credit card on file.

CREDIT CARD: □ AMEX □ VISA □ MC □ DISCOVER

CARDHOLDER'S NAME: _____

BILLING ADDRESS: _____

CARD #: _____ EXP. DATE: _____

THREE DIGIT CID NUMBER: _____

I have read and agree to the above conditions. I authorize you to charge the above credit card any payment for missed sessions where 24 hour notice isn't provided by me.

Name _____ Date _____