PCA
Psychiatric and Counseling Associates

Brent Menninger, M.D.
Nancy Pierce, APRN
Diane Gaunt, APRN
K. Bryce Jones, LCMFT

Informed Consent for Psychotherapy

You have taken a very positive step in deciding to seek therapy. The therapeutic relationship is unique and highly personal, but it is also a contractual agreement. In light of this, it is important to reach a clear understanding of how our relationship will work, and what each of us can expect. The following concerns will provide a clear framework for our work together. If you have any questions after reading this document, do not hesitate to ask for clarification. Please indicate that you have reviewed this information by providing your signature at the end of this page. The outcome of your treatment depends largely on your willingness to engage in this process, which at times, may result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings such as anger, depression and anxiety etc. There are no miracle cures, and I cannot guarantee specific outcomes; however, I can promise to support you and you do my very best to understand you and any repeating patterns, as well as to help you clarify what it is that you want for yourself.

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such clients held privilege of confidentiality exist and are specified below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens great bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and #4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

Occasionally, the need to consult with other professionals and areas of expertise in order to provide the best treatment for you does occur. Information about you may be shared in this context without using your name.
If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak with you briefly, but I feel it's not appropriate to engage in any lengthy discussion in public or outside of the therapy office.

Patient Name: _____ Patient Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____

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Coordination of Care

I understand under the provisions of KSA 65-6404, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that he or she may have observed while working with me or my minor child(ren) listed below. In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my therapist has/have recommended that I seek medical consultation.

Name(s) of Minor Child	Name(s) of Minor Child

By signing I am indicating that I waive my right to such consultation, and I am aware that this waiver will become part of my client record.

Client Signature(s)	Therapist Signature(s)

8400 W 110th ST STE 250 Overland Park, KS 66210-2331
913-327-7505 Phone 913-327-7054 Fax
www.pca4u.com

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Name	Date

Check any of the following terms that apply to you (Self =S)
Check any of the following terms that you have noticed in a family member (family = F)

S	F		S	F		S	F	
		Depressed mood			Significant on going physical pain			Drug usage
		Lost interest or pleasure			Stomach problems			Marital problems
		Lack of energy/fatigue			Headaches			Divorce
		Weight gain or loss			Bowel problems			Separation
		Unable to concentrate			Balance problems			Affair
		Excessive sleeping			Seizure problems			Problems with ex/spouse
		Difficulty sleeping			Learning/academic problems			Relational problems
		Decreased need for sleep			Stuttering problems			Parenting problems
		Pressure to keep talking			Frequent “on the go” behavior			Problems with friends
		Racing thoughts			Impulsive behavior			Problems with children
		Excessive risk taking behavior			Temper			Legal problems
		Panic attacks			Aggressive behavior toward others			Financial problems
		Excessive fear of situation/object			Destructive behaviors			School problems
		Reoccurring thoughts or impulses			Frequent lying/deceitfulness			Shyness
		Repetitive behaviors to reduce stress			Problems following rules			Anger
		Witness/experience event threatening life or serious injury			Sexual problems			Loneliness
		Excessive anxiety or worry			Eating problems			Insecurity
		Hear/see things others do not			Nightmares			Isolation
		Memory problems/memory loss			Gambling problems			Alcohol usage

If you have noticed any <u>recent changes</u> in the following areas **<u>please circle those changes</u>**.

Vision	Hearing	Coordination	Balance	Strength	Speech	Memory
Energy	Sleeping	Menstrual Cycle	Elimination	Eating	Sexual Activity	Thinking

List any additional medical problems you may be experiencing.

_____

_____

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List any counseling or therapy you, or a member of your family, are receiving or have received.

Therapist	Address	When	Family member

Have you ever been physically, sexually, emotionally abused? No Yes

If yes, briefly describe:

_____

_____

Have you ever been hospitalized for mental or nervous problems? No Yes

If yes, when and where:

_____

_____

Have you ever attempted suicide? No Yes

If yes, where, when and how many attempts?

_____

_____

Are you suicidal now? No Yes

Do you drink alcohol? No Yes

If yes, what is your typical drink and how often do you drink alcohol? _____

Age of first alcohol use _____ Age of heaviest/most frequent use _____ Use in last three months _____

Have you ever been arrested for driving under the influence (DUI)? No Yes If yes, how many times? _____

Do you use drugs? No Yes

If yes, what drugs do you use and how often? _____

Age of first drug use _____ Age of heaviest/most frequent use _____ Use in last three months _____

Have you ever been arrested? No Yes If yes, how many times and what for? _____

Are you currently involved or do you expect to be involved in any court-related matters? No Yes

If yes, please describe:_____

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What is in your marriage, family or individual life that brings you to therapy?

What kinds of stressors are you experiencing right now?

What important things about your marriage or family would it be helpful for your therapist to know (i.e. illness, handicaps, deaths, divorce, school/job changes, suicide)?

Do you have any concerns about violence or abuse in your family? Alcohol or drug use? Please describe them.