Phoenix Rising Counseling, PC
Leyla Dim, LPC
2610 Big Horn Ave
Cody, WY 82414
Office: 307-587-6288
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INFORMED CONSENT AGREEMENT

I believe the best relationships are those that are built on respect and understanding. My policies will give you understanding as to how I work, how the professional coaching and counseling relationship works and your responsibilities as a client. Please read and sign where indicated below regarding release of all liability for all parties as the informed consent outlines below.

Professional Statement

People seeking counseling and wellness services are wanting to better their lives. They are people who realize their personal, relational, family or professional life could be better. They have chosen counseling as a way towards self-discovery and understanding. The use of other healing modalities such as, neurotherapy services, biofeedback and any other modality in the treatment paradigm are also treated with the same level of professional regard, ethics and release of liability for the practitioner and assistants.

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Integrative therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist and treatments you select. Please feel free to ask me any questions about my professional background and therapeutic modality. After all, this process is about you and it is important to feel confident in your provider. If you have questions about my procedures, we should discuss them whenever they arise. It is understood that your decision for any type of treatments or services with

Leyla Dim, LPC, Phoenix Rising Counseling or Lokahi Wellness releases any of such entities and practitioners from any and all liability.

Meetings

I normally conduct an initial consultation to identify presenting issues and begin working towards formulating treatment goals. During this time, we can both decide whether I am the best person to provide the services you need in order to meet your treatment goals. If therapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment is scheduled, I expect a call prior to the appointment time if it needs to be canceled or rescheduled. When I am not notified that you do not plan to attend and you do not come to the appointment, you will be responsible for the full payment, not your insurance company. If I need to cancel an appointment I will give as much advance notice as possible to you as well.

With neurotherapy and biofeedback services it may be a trained technician providing services under the clinical supervision of Leyla Dim, LPC. It is understood that all parties have agreed to the treatment plans being implemented.

Professional Fees

My customary hourly fee is $150. This fee occasionally will vary given the contract for services and agreed upon treatment plan. Initial consultations will be billed at $150.00. Neurotherapy services with Leyla Dim, LPC are $180/hour, unless otherwise specified. Neurotherapy with a technician is $120/hour. Brain Mapping, QEEG, report and consultation is $800. Insurance may cover some expenses and I can offer, upon request, an invoice with appropriate insurance codes for you to submit to your insurance company

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless I have a contract that your services are paid by an outside agency like private health insurance. If the outside agency does not reimburse for services that have been delivered, you will be responsible for the bill. Payment schedules for other professional services will be agreed to when they are requested. It is understood that you are responsible for payment for services.

I do not bill or invoice for services. All services are expected to be paid for at the time of appointment unless otherwise agreed upon in writing. Let me know if you are

needing an invoice to submit for insurance.

Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. If I bill the insurance company directly for my services it is my expectation that you are familiar with what your co-pay is for services. It is understood that this is to be paid upon completion of each session. If you do not know what the co-pay is then it is expected that you will pay half of the agreed upon fee at each session.

Contacting Me

I can be reached at 587-6288. I am often not immediately available by telephone as I am usually in session during the day. I check my messages frequently and will return you call within 24 hours, though it is usually by the end of the present day. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health professional on-call. If I will be unavailable for an extended time, I will advise you and help you to make arrangements for additional support services during the time that I am gone if needed.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete, and discuss it with you before providing it to them. Before giving them any information, I will discuss this matter with you, if possible, and do my best to handle any objections you may have about what I am prepared to discuss.

Confidentiality

In general, the law protects the privacy of all clinical communications between a client and a counselor, and I can release information about our clinical work to others only with your written permission. But there are a few exceptions.

In most legal proceedings , you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody, the validity of a will of a former client being contested, and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it. Another situation where relaying information related to counseling is necessary is to defend against a malpractice action brought by a client or in the context of an investigation and hearing brought by the client and conducted by the board, where violations of this act are at issue.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the Division of Family Services.

If I believe that a client is threatening seriously bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any actions. I may occasionally find it helpful to consult other professional about a case. During a consultation, I make every effort to avoid revealing the identity of my client or I may request a release from you for permission to consult with another professional. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. Please read your Notice of Privacy Practices for more detailed information.

Qualification to Practice

I am a licensed professional counselor (LPC) in Wyoming, **LPC-1102**. The address of the licensing agency is: Mental Health Licensing Board, 1800 Carey Ave, 4th Floor, Cheyenne, Wyoming 82002. Their telephone number is 307-777-6529. I follow the Code of Ethics of the American Counseling Association. This disclosure statement is required by the Mental Health Professions Licensing Act.

As a coach, neurotherapist and healing practitioner I am released from all liability as I am not providing service under my licensure as a licensed professional counselor in Wyoming. In these professional relationships there is no clinical contract for services explicitly or implicitly stated. The boundaries of the professional relationship are clearly delineated.

Notice of Privacy Practices & Professional Disclosure Statement

Purpose: Your protected health information (PHI) is any information we have about your that may identify you, and that relates to the mental health treatment provided to you, the payment for these services, and your mental health condition in the past, present, or future. This Notice of Privacy practices describes how we may use and disclose your PHI for the purposes of treatment, payment, and healthcare operations and it also describes your rights to access your PHI.
Definition of Treatment, Payment, and Health Care Operations: To maximize your mental health services, the clinician may need to share your mental health records with other designated professionals, i.e. diagnosis, treatment dates, etc., in order to coordinate your care. My billing service is Mountain Medical Services. In order to receive third party reimbursement, a diagnosis, dates and length of service are usually required.

Use and Disclosure of Protected Health Information: This clinician will use and disclose your protected health information to carry out treatment and payment for treatment. Further, as allowed by Federal and State law, this clinician may use and disclose your protected health information without your written consent or authorization under the following circumstances:

- To a personal representative legally designated by you to receive you PHI, or a personal representative designated by law, such as a parent/legal guardian of a child.

- When a disclosure is required by federal, state, or local law, judicial or administrative proceeding, or law enforcement. For example, I may disclose information about suspected child or elderly abuse and/or neglect, or when ordered by judicial or administrative proceedings, or to report criminal activities.
- To a health oversight agency for activities authorized by law such as audits, investigations, inspections, licensure or disciplinary proceedings, etc.
- For public health activities such as for the purpose of preventing or controlling communicable diseases, or for providing coroners and medical examiners information related to an individual's death.
- To prevent a serious identifiable threat to health or safety (yourself or others).

Other disclosures Requiring Your Authorization: Except as described in previous sections, this clinician will not use or disclose your protected health information without your written authorization. You may revoke this authorization at any time, except to the extent that the use or disclosure has already occurred.

Your Rights Regarding the Use and Disclosure of Your Protected Health Information: You have the following rights regarding protected health information:

- Right to request restriction. You may request restrictions on the use and disclosure of your protected health information, but this clinician is not required to agree to your request. If the restriction is granted, the clinician will comply with the request unless it is necessary to use or disclose information to provide you or your minor child/children with emergency treatment.
- Right to inspect and copy your protected health information. You may request, in writing, to inspect and copy your health information, with the exception of therapy notes or information that has been provided by a third party. The clinician may charge a fee for copying, as well as postage if mailed. Under certain circumstances your request may be denied, for example, if the request is contraindicated to treatment.
- Right to request an amendment of, or change to, your protected health information. If you believe that your health information is incorrect or incomplete, you may request an amendment to the information. The clinician will consider the request, but is not required to comply with your request.
- Right to receive an accounting of disclosures of your protected health information. You may request a list of disclosures of your health information that have been made other than for treatment, payment, or health care operations.
- Right to obtain a paper copy of the Notice of Privacy Practices upon request. You may request a copy of this notice at any time.

Requirements Regarding this Notice of Privacy Practices: This clinician is required by law to maintain the privacy of protected health information and to provide you with the Notice of Privacy Practices. This clinician reserves the right to change the terms of this Notice. When these changes occur, the changes will be effective for all health information we currently maintain for you as well as any information received about you in the future. When changes to this Notice are made, a revised Notice will be made available to you at your request.

Additions or Exceptions to Contract

***Please return this last sheet to me as acknowledgement of having received the informed consent agreement and keep the agreement for your records.**

Acceptance of Informed Consent Agreement

Your signature below indicates that you have read the information in the Informed Consent Agreement and agree to abide by its terms during our professional relationship.

Your signature:_____________________________Name (printed):___________________

Date: ______________________

I have received the Notice of Privacy practices and Professional Disclosure Statement:

Your Initials: _________

Please check the service below that you are seeking assistance with or coming for:

______Initial Consultation

______Individual Counseling

______Marriage or Relationship Therapy

______Neurotherapy

______Life Coaching

______Clinical Hypnosis

______Integrative Mind/Body Therapy, including healing modalities

______LENS Neurofeedback

______QEEG/Brain Mapping

LENS INTAKE FORM

Name:________________________________ Date of Birth:____________________

Address:_______________________________Email:_________________________

PRESENTING ISSUES FOR LENS TREATMENT:

____

____

____

____

____

____

____

History and how long:

____

____

____

____

____

____

____

How were you before these problems occurred (if relevant)?

____

____

____

____

How is this impacting your life now:

____

____

____

____

Current medications and reasons for taking them:

____

____

____

____

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Basis for Incomplete Problem Resolution:
(Please answer Yes/No for Past/Present)

	PAST	PRESENT
1. Unpredictable things had a big effect on me.	_____	_____
2. Situations were embarrassing for me.	_____	_____
3. Friends and/or family had a hard time being around me.	_____	_____
4. I was troubled by emotions/feelings.	_____	_____
5. I had problems like seizures, tics, migraines, headaches, cluster headaches, stuttering, Tourett's, explosiveness.	_____	_____

6. History of concussions, brain injuries? How many, when and details:

7. History and details of neurological issues?

Details:____

8. Health issues and/or concerns? ____

____

How will you know you're done with treatment?

TOP 5 SYMPTOMS: WHAT ARE WE TREATING? (sleep/memory/energy/focus/etc.)

1____

2____

3____

4____

5____

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BRAIN INVENTORY

Please read this list of behaviors and rate yourself (or the person you are evaluating) on each behavior listed. Use the following scale and place the appropriate number next to the item. (DL)

0 = never

1 = rarely

2 = occasionally

3 = frequently

4 = very frequently

___ 1. Feelings of sadness

___ 2. Moodiness

___ 3. Negativity

___ 4. Low energy

___ 5. Irritability

___ 6. Decreased interest in others

___ 7. Feelings of hopelessness about the future

___ 8. Feelings of helplessness or powerlessness

___ 9. Feeling dissatisfied or bored

___ 10. Excessive guilt

___ 11. Suicidal feelings

___ 12. Crying

___ 13. Lowered interest in things usually considered fun

___ 14. Sleep changes (too much or too little)

___ 15. Appetite changes (too much or too little)

___ 16. Low self-esteem

___ 17. Decreased interest in sex

___ 18. Negative sensitivity to smells or orders

___ 19. Forgetfulness

___ 20. Poor concentration

(BG)

0 = never

1 = rarely

2 = occasionally

3 = frequently

4 = very frequently

___ 1. Feelings of nervousness or anxiety

___ 2. Panic attacks

___ 3. Symptoms of heightened muscle tension (headaches, sore muscles, hand tremor)

___ 4. Periods of heart pounding, rapid heart rate, or chest pain

___ 5. Periods of trouble breathing or feeling smothered

___ 6. Periods of feeling dizzy, faint, or unsteady on your feet

___ 7. Periods of nausea or abdominal upset

___ 8. Periods of sweating, hot or cold flashes, cold hands

___ 9. Tendency to predict the worst

___ 10. Fear of dying or doing something crazy

___ 11. Avoidance of public places for fear of having an anxiety attack

___ 12. Conflict avoidance

___ 13. Excessive fear of being judged or scrutinized by others

___ 14. Persistent phobias

___ 15. Low motivation

___ 16. Excessive motivation

___ 17. Tics

___ 18. Poor handwriting

___ 19. Quick startle reaction

___ 20. Tendency to freeze in anxiety-provoking situations

___ 21. Excessive worry about what others think

___ 22. Shyness or timidity

___ 23. Low threshold of embarrassment

(CI)

0 = never

1 = rarely

2 = occasionally

3 = frequently

4 = very frequently

___ 1. Excessive or senseless worrying

___ 2. Being upset when things do not go your way

___ 3. Being upset when things are out of place

___ 4. Tendency to be oppositional or argumentative

___ 5. Tendency to have repetitive negative thoughts

___ 6. Tendency toward compulsive behaviors

___ 7. Intense dislike of change

___ 8. Tendency to hold grudges

___ 9. Trouble shifting attention from subject to subject

___ 10. Trouble shifting behavior from task to task

___ 11. Difficulties seeing options in situations

___ 12. Tendency to hold on to own opinion and not listen to others

___ 13. Tendency to get locked into a course of action, whether or not it is good

___ 14. Being very upset unless things are done a certain way

___ 15. Perception by others that you worry too much

___ 16. Tendency to say no without first thinking about questions

___ 17. Tendency to predict negative outcomes

(TL)

0 = never

1 = rarely

2 = occasionally

3 = frequently

4 = very frequently

___ 1. Short fuse or periods of extreme irritability

___ 2. Periods of rage with little provocation

___ 3. Frequent misinterpretation of comments as negative when they are not

___ 4. Irritability that tens to build, then explodes, then recedes; person often feels tired after a rage

___ 5. Periods of spaciness or confusion

___ 6. Periods of panic and/or fear for no specific reason

___ 7. Visual or auditory changes, such as seeing shadows or hearing muffled sounds

___ 8. Frequent periods of déjà vu (feelings of being somewhere you have never been) or jamais vu (not recalling a familiar place or person)

___ 9. Sensitivity or mild paranoia

___ 10. Headaches or abdominal pain of uncertain origin

___ 11. History of a head injury or family history of violence or explosiveness

___ 12. Dark thoughts, such as suicidal or homicidal thoughts

___ 13. Periods of forgetfulness

___ 14. Memory problems

___ 15. Reading comprehension problems

Sensitivity Questionnaire

People are so amazingly different. Below is a list of statements that other clients have made about themselves. For each statement that is true, please indicate on a scale from **1-10,** where "**1**" indicates the statement is rarely so, and '**10**" indicates the statement is always so. Do not mark the statements that are nottrue for you.

1~ Never True thru 10~ Absolutely True

SENSITIVITY

I feel when the weather is about to change.	
I can easily tell whether a medication is going to work or not	
I can sense unhealthy environments and then take care of myself.	
I can sense my need for food before I even feel hungry.	
I can sense smells and scents that others seem not to notice.	
I feel beforehand when I'm about to come down with a cold or flu.	
I have a wide appreciation for tastes in different foods.	
I can feel the difference between quietness and stillness.	
I can feel the difference between relaxation and comfort.	
I select my friends by how I feel when I'm with them rather than by appearances.	
I sense mood, energy shifts, and attention changes in people around me.	
I need to do things at my own pace.	
I am very creative.	
I know quickly when something is going to work out-such as a job or relationship.	
I have some abilities that some people consider psychic.	

REACTIVITY

I have unpleasant reactions to certain weather changes	
I have unpleasant reactions to certain foods	
I have don't like or have a bad reaction to certain smells, lighting and textures	
I have unpleasant reactions to certain medications	
I have chronic pain that gets worse with stress	
I have unpleasant reactions to not eating when I need to	
I can be shocked by my reactions and/or get upset easily	

HARDINESS

Certain unpredictable things used to have a big effect on me but no longer do	
I have almost forgotten how embarrassing things used to be for me.	
My friends & family have a hard time being around me	
I'm not troubled by any unwanted emotions & feelings	
In the past I had problems like migraines/tics/seizures/explosiveness that I no longer have	
I can work in spite of pain	
When life hits me hard I get back on my feet quickly	
I can do a lot of planning & thinking without getting tired	

CNS Functioning Assessment

Name:______________________________ **Date of Birth:**_______________ **Age:** ___

Today's Date:________________________ **Time:**__________ **Diagnosis:**____________

Are you able to drive a motor vehicle?	**Yes**	**Partially**	**No**
Are you able to work or study?	**Yes**	**Partially**	**No**
Are you able to sustain a close relationship with someone?	**Yes**	**Partially**	**No**

How frequently, in the past 24 hours or weekly, have you had any of the following issues?

Please pick a number from O to 10. "O" means Not at all, and "10" means All the time.

If one or both of your parents had this, place an (X) in the column headed by "Parents?"

If the problem came on suddenly, put an (X) in the column head by "Suddenly?"

Sensory	**Frequency (0-10)**	**Parents?**	**Suddenly?**
Light, in general, or lights, bother you	__________	__________	__________
Problems with the sense of smell	__________	__________	__________
Problems with vision	__________	__________	__________
Problems with hearing	__________	__________	__________
Problems with the sense of touch	__________	__________	__________
Emotions			
Problems of sudden, unexplained changes in mood	__________	__________	__________
Problems of sudden, unexplained fearfulness	__________	__________	__________
Problems of unexplained spells of depression	__________	__________	__________
Problems of unexplained spells of elation	__________	__________	__________
Problems with explosiveness	__________	__________	__________
Problems with suicidal thoughts or actions	__________	__________	__________

Clarity

Feel "foggy" and have problems with clarity	______	______	______
Problems following conversations (with good hearing)	______	______	______
Problems with confusion	______	______	______
Problems following what you are reading	______	______	______

	Frequency (0-10)	**Parents?**	**Suddenly?**
Realize you have no idea what you have been reading	______	______	______
Problems with concentration	______	______	______
Problems with attention	______	______	______
Problems with sequencing	______	______	______
Problems with prioritizing	______	______	______
Problems not finishing what you start	______	______	______
Problems organizing your room, office, paperwork	______	______	______
Problems with getting lost in daydreaming	______	______	______
You cover up that you don't know what was said or asked of you	______	______	______

Energy

Problems with stamina	______	______	______
Fatigue during the day	______	______	______
Trouble sleeping at night	______	______	______
Problems awakening at night	______	______	______
Problems falling asleep again	______	______	______

Activation or Anxiety

Restlessness	______	______	______
Problems with irritability	______	______	______
Daydreaming	______	______	______
Worrying	______	______	______
Always moving	______	______	______
Cold hands or feet	______	______	______
Palpitations	______	______	______

Memory

Forgot what you have just heard	________________	_________	__________
Forgot what you are doing, what you need to do	________________	_________	__________

Movement

	Frequency (0-10)	Parents?	Suddenly?
Problems with procrastination and lack of initiative	________________	_________	__________
Problems with name recall, tracking conversation	________________ _	_________	__________
Problems not learning from experience	________________	_________	__________
Movement			
Problems with paralysis of one or more limbs	________________	_________	__________
Problems focusing or converging the eyes	________________	_________	__________
Problems with balance	________________	_________	__________
Pain			
Head pain that is steady	________________	_________	__________
Head pain that is throbbing	________________	_________	__________
Shoulder and neck pain	________________	_________	__________
Wrist pain	________________	_________	__________
Tender areas of muscles	________________	_________	__________
All-over pain	________________	_________	__________
Joint pain	________________	_________	__________
Other pain____________________(specify)	________________	_________	__________

LENS References
2014

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