MALOTT COUNSELING SERVICES

Zach Malott, MA, LMHC, LADAC
1096 Mechem Dr, Ste 212
Ruidoso, NM 88345
zmalott@therapist.net
575-489-5244

Name: _____Date: _____

Date of Birth: _____ Age: _____

Address: _____
Street City State Zip

Phone: (H)_____ (W)_____(C)_____

Emergency Contact: _____

Why are you seeking treatment at this time_____

_____

For Therapist Use Only

Presenting Problem:
Symptoms:
History of Problem:

MARITAL & FAMILY INFORMATION:

Current Status:

❑Single ❑Married ❑ Re-Married ❑Separated ❑ Divorced ❑ Widowed ❑ Living Together

I identify as: ❑Heterosexual ❑Gay ❑Lesbian ❑Bisexual ❑Transgendered ❑Intersexual

1st Marriage: _____age _____year _____# of children _____if divorced, year
(or long-term relationship)

2nd Marriage: _____age _____year _____# of children _____if divorced, year
(or long-term relationship)

3rd Marriage: _____age _____year _____# of children _____if divorced, year
(or long-term relationship)

Current relationship: ❑ Excellent ❑Good ❑Fair ❑Poor

Conflicts over: ❑Friends ❑Jobs ❑Money ❑Alcohol/Drugs ❑Legal ❑Sex
❑Mental Health Issues ❑Communication ❑In-Laws
❑Other (specify) _____

Comments: _____

With whom are you currently living?

Name	Age	Relationship

Children NOT living with you:

Name	Age	Lives with

FAMILY OF ORIGIN:

Place of birth: _____
City State Country

Race: ❑African-American ❑Caucasian ❑Native American ❑Hispanic ❑Asian ❑Latino

❑Multi-Racial ❑Other (specify) _____

Parent's Present Marital Status: _____

Father: ❑Living ❑Deceased, year:_____ Education _____ Occupation_____

Mother: ❑Living ❑Deceased, year:_____ Education _____ Occupation _____

Describe relationship w/Father: _____

Describe relationship w/Mother: _____

Number of Siblings: ____ Full Sisters ____Full Brothers ____½Sisters ____½ Brothers
____Step Sisters ____Step Brothers

Number of siblings deceased: _____ Age(s) at time of death: _____

Describe relationship w/siblings: _____ Describe your

childhood:

_____

_____

Were you ever physically / sexually abused? ❑No ❑Yes ❑Don't Know
By whom: _____ Age of onset: _____

Are there Mental Health, Emotional Problems, Drug or Alcohol problems in your family? ❑No ❑Yes
Who:_____ Type of Problem: _____

Anyone in your family ever commit suicide? ❑No ❑Yes Who: _____

OTHER INTERPERSONAL RELATIONSHIPS:
How do you describe your friendships: ❑No Friends ❑Only Acquaintances ❑Acquaintances & Friends Number of close friends: _____

EDUCATION / VOCATION:
Highest degree of education: ❑Grade ❑G.E.D. ❑College ❑Degree ❑Advanced Degree

Partner's highest education: ❑Grade ❑G.E.D. ❑College ❑Degree ❑Advanced Degree

Vocational Training (specify):
_____

Are you currently employed: ❑No ❑Yes Title:
_____

How long in this job: _____ Months / Years Are you happy with the job? ❑No ❑Yes

Comments: _____
Work History:
Job Length of Time Reason for Leaving

_____

_____

_____

_____

Military Service: ❑No ❑Yes (specify) _____

Rank: _____ Branch: _____ Saw Combat? ❑No ❑Yes

Honorable Discharge: ❑No ❑Yes

LEISURE ACTIVITIES:

List hobbies, talents, activities for stress relief: _____

_____

LEGAL STATUS:

Have you ever been convicted of a crime? ❑No ❑Yes

Charge Age Outcome Related to Drugs / Alcohol

_____

_____

MEDICAL HISTORY:

How is your general health? ❑Good ❑Fair ❑Poor

Name of Physician: _____

Date of last physical exam: (month) _____ (year): _____

I can't remember the exact date, but approximately _____ years ago.

Medical Health concerns:

_____

_____ How is your:

Sleep? ❑Good ❑Fair ❑Poor Explain: _____

Appetite? ❑Good ❑Fair ❑Poor Explain: _____

Sexual satisfaction? ❑Good ❑Fair ❑Poor Explain: _____

Please list current prescribed and/or over-the-counter drugs/medications (if none, check this box ❑):

Name_____ Dosage_____

Physician_____

Name_____ Dosage_____

Physician_____

Name_____ Dosage_____ Physician_____

Name_____ Dosage_____ Physician_____

Please complete the chart below **SUBSTANCE USE / ABUSE:**

Category of Drug	Have you ever used?	Currently using?	Age at first use	How often do you use?	How taken?	How much?	Use last 48 hours?	Withdrawal symptoms
Alcohol	❑No ❑Yes	❑No ❑Yes						
Stimulant	❑No ❑Yes	❑No ❑Yes						
Cocaine	❑No ❑Yes	❑No ❑Yes						

Tranquilizer	❑No ❑Yes	❑No ❑Yes						
Barbituate	❑No ❑Yes	❑No ❑Yes						
Marijuana	❑No ❑Yes	❑No ❑Yes						
Opiod	❑No ❑Yes	❑No ❑Yes						
Hallucinogen	❑No ❑Yes	❑No ❑Yes						
Prescribed	❑No ❑Yes	❑No ❑Yes						
Nicotine	❑No ❑Yes	❑No ❑Yes						
Caffeine	❑No ❑Yes	❑No ❑Yes						
Other	❑No ❑Yes	❑No ❑Yes						

Specific Drug / Alcohol of Preference: _____

Do you use Drugs / Alcohol in combination? ❑No ❑Yes Describe: _____

Ever treated for alcohol poisoning? ❑No ❑Yes Number of blackouts: _____

AA attended? ❑No ❑Yes, Year(s): _____ NA attended? ❑No ❑Yes, Year(s): _____

For Therapist Use Only

Substance Use / Abuse / Dependence: ❑NO SA Problems / Concerns

❑Increased tolerance over time ❑Work problems related to use
❑Relationship problems related to use
❑Family history of ❑Drinks to intoxication _____ times a month ❑Cravings / Withdrawal symptoms
❑# DUI's _____
❑Further screening indicated ❑Referral indicated
Comments:

RELIGION / SPIRITUALITY:

❑Protestant ❑Catholic ❑Buddhist ❑Hindu ❑Jewish ❑Muslim ❑Atheist ❑Agnostic

❑Other: _____

Are you currently active in religious or spiritual affairs? ❑No ❑Yes
If yes, in what capacity? _____

Are you satisfied with your current level of religious or spiritual activity ❑No ❑Yes
If no, why not? _____

PREVIOUS THERAPY / PSYCHIATRIC SERVICES:

Have you ever been in counseling before? ❑No ❑Yes, ❑Inpatient ❑Outpatient ❑Day Treatment

Name of Provider Clinic Year Diagnosis / Problem

_____
_____
_____

Have you ever seen a Psychiatrist before? ❑No ❑Yes, ❑Inpatient ❑Outpatient ❑Day Treatment

Name of MD: _____ Clinic:_____

Was any of your previous therapy related to substance abuse? ❑No ❑Yes
Have you ever had serious thoughts of suicide or homicide? ❑No ❑Yes
Have you ever made a suicide / homicide attempt? ❑No ❑Yes Explain: _____
_____

Do you presently feel suicidal or homicidal? ❑No ❑Yes Explain:
_____
_____

_____
Client Signature Date

_____
Therapist Signature Date

For Therapist Use Only

SAFETY:

❑ Client **denies current** suicidal / homicidal ideation, intentions, or plans.
❑ Client **reports current** suicidal / homicidal ideation, intentions, or plans.
❑ Client **denies history** suicidal / homicidal ideation, intentions, or plans. ❑ Client **has a history** suicidal / homicidal ideation, intentions, or plans.

Specify if any: _____
Therapist: _____
❑ None Needed

MENTAL STATUS:

General Behavior: cooperative, passive, withdrawn, dramatic, restless, hostile, anxious, other _____

Attire: appropriate, seductive, untidy, loud, meticulous, other _____

Gait: normal, erect, stooped, ataxic, rigid, shuffling, manneristic, other _____ Motor Activity: normal, agitated, retarded, tremor, tic, mannerism, other _____ Stream of Thought:

Productivity: spontaneous, verbose, pressured speech, unproductive, other _____

Progression: normal, loose, circumstantial, preservation, halting, blocking, incoherent, fragmented, other _____

Language: normal, baby-talk, peculiar, expression, stilted, other _____

Emotional Tone & Reactions:

Mood: normal, indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, composed, anxious, sad, tearful, depressed, other _____

Affect: appropriate, inappropriate, other _____ Mental Trend / Content of Thoughts:

Perception: normal, auditory hallucination, visual hallucination, illusions, depersonalization,hypochondriasis, other _____

Orientation: normal, disoriented to time, place, person, other _____

Memory: normal, defective (remote, recent, immediate), other _____

General Knowledge: consistent with education, inconsistent, able to abstract, concrete, other _____ Insight: absent, good, fair, minimal Judgment: good, fair, poor

DIAGNOSTIC SUMMARY:

For Therapist Use Only

Diagnostic Impressions:

For Therapist Use Only

Goals for therapy:

1.

2.

3.

4.

5.

_____

Therapist Signature Date

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MALOTT COUNSELING SERVICES AGREEMENT

This agreement for counseling shall govern all professional relations between the parties. It is agreed that any disputes or modifications of agreement shall be negotiated directly between the parties; if negotiations are not satisfactory, then the parties agree to mediate any differences with a mutually acceptable third-party mediator, if this is not satisfactory, Malott Counseling Services will give you the information of how to present a grievance with the Counseling and Therapy Board of New Mexico.

A. THE COUNSELOR is Zach Malott, MA, LMHC, LADAC. I am an SBC Ordained Pastor and an AACC Pastoral Counselor-Certified. I hold a Master's Degree in Professional Counseling from Liberty University in Lynchburg, VA and licensed as a Licensed Mental Health Counselor (LMHC) and a Licensed Alcohol and Drug Abuse Counselor (LADAC) in the State of New Mexico.

B. I am trained and experienced in both Pastoral and Professional Counseling. Personal problems can come about because of physiology, social-environmental influences, psychological pressures, and spiritual reasons. Treatment consists of an evaluation to determine the type and depth of the issue(-s) you are experiencing. A treatment plan is developed in collaboration with you, and set into motion in the second session. I generally treat from a Cognitive Behavioral Therapy (CBT) model and utilize other modalities where necessary. CBT is considered brief therapy and most situations can be helped within 8 to 12 sessions. Further treatment may be agreed upon at the end of this time to continue counseling with Zach Malott or referral elsewhere if needed, whichever is in the client's best interest.

C. FEES POLICY: Client fees are to be as follows:

The first appointment is for building rapport between client and therapist, complete assessment instruments, etc. There will be an assessment to determine an appropriate diagnosis of the problem(s) the client may be experiencing as well as the direction treatment might take. The assessment will consist of certain instruments chosen based upon the client's presenting issues. The fee for the session is $80.00 + tax and the one-time assessment is $45.00.

a. The total for the first session/assessment is $125.00+tax.

b. Each session thereafter will be $80.00 + tax.

Full payment shall be made at time of service by the client. Clients are scheduled for 45-50 minute sessions leaving 10-15 minutes between sessions for the appropriate paperwork for each client to be completed after session. It is understood by the undersigned client that MCS **does not** accept insurance and payment for all sessions are to be paid in full at the beginning of each session.

Appointments will not be scheduled beyond any unpaid session until payment is made, unless special arrangements have been made. Client checks returned for non-payment are subject to prosecution. It is the practice and desire of MCS to resolve such issues by using a different alternative. If this situation arises client will be charged a $25.00 fee in addition to the bank charge for returned check and will be given the opportunity to pay the face amount on the original check in cash. Client will be required to pay cash or debit/credit card for all further counseling sessions. Clients are fully responsible for the payment of all fees.

D. CANCELLATION POLICY Client agrees to maintain responsible relations regarding appointment times. Reminder calls are not made unless client makes special request for such calls. Any appointment cancelled in less than twenty-four (24) hours of the scheduled appointment or if the client does not show up, is subject to be charged at the regular fee rate. If client cancels three (3) consecutive appointments, counselor and client will discuss commitment to the counseling process and the possibility of termination. In this situation, if client requests to continue, client will be asked to make payment prior to rescheduling.

E. CONFIDENTIALITY POLÍCY: All therapeutic communications and records will be held in strict confidence. For that reason, MCS will not appear in court on your behalf as it may do harm to you as well as others. Information may only be released, in accordance with the state law and only when (1) the client signs a written release of information indicating informed consent to such release; (2) the client expresses serious intent to harm himself/herself or someone else; (3) there is evidence or reasonable suspicion of abuse against a minor child, elderly person (sixty-five years or older), or dependent adult; or (4) a subpoena or other court order is received directing the disclosure of information. The policy of MCS asserts either (a) privileged communication in the event of #4 or (b) the right to consult with clients, if possible, before mandated disclosure in the event of #2 or #3. Although it cannot be guaranteed as Zach Malott is a mandated reporter, it will be endeavored to inform clients of all mandated disclosures. Clients with any concerns or questions about this policy agree to raise them with me at the earliest possible time to resolve them in the client's best interest.

F. WORK AGREEMENT: It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority in his or her life. Client gain and self-respect is most important in counseling. Therefore, client is asked to refrain from any unconstructive behavior within the premises of MCS. Termination or referral shall be discussed between counselor and client for behavior that reveals disinterest or lack of commitment and for any unresolved conflict or impasse between counselor and client. Upon a 30-day absence by client without contact or notice of intent to MCS, it is understood and agreed by both parties that termination of counselor/client relationship will automatically take place without notice. If client desires to reestablish a relationship with me after a lengthy absence they must date and sign new work agreement. A client shall not bring children with them to a session. We do not have the facilities for young children to be looked after or special room for them nor is it conducive for therapy.

Service Agreement: I/We, the undersigned counselor and client, have read and fully understand this agreement and the stated policies. We agree to honor these policies, including the commitment to negotiate and mediate as stated above, and will respect one another's views and differences in their outworking. We have also agreed to an initial definition of counseling work and to the fee to be paid by the client. By signing client acknowledges that he/she is fully responsible for any decisions he/she makes regarding his/her life and circumstances and hereby absolves Zach Malott from all liability regarding the counseling that is provided.

Client Signature _____Date_____

Client Signature _____Date_____

Client's Parent or Guardian_____Date_____

Counselor signature_____Date_____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. Please request if you would like to view.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or your provider.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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AUTHORIZATION FOR RELEASE OF INFORMATION

NOTICE TO CLIENTS:

Malott Counseling Services (MCS) may not condition treatment, payment, enrollment, or eligibility for benefits or treatment on whether the client signs this, or any other, authorization to release information.

I, _____hereby authorize **MALOTT COUNSELING SERVICES**
Name of Client
To release the information described below to _____
Name of Person and/or organization Receiving Information

This authorization may be revoked at any time by myself and will automatically expire one (1) year from today _____, 20_____.

Specific type of information to be disclosed:
_____

_____

For the purpose of: _____
_____

I understand that this health information may include HIC-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance use disorder and that by signing this form I am specifically authorizing the release of information relating to:

___ Substance Use disorder (including alcohol/drug use/abuse)
___ Mental Health
___ Psychotherapy Notes or Information Therein
___ HIV-related Information (including AODS-related testing)

The confidentiality of this information is required under U.S. Federal and State of New Mexico statutes. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes. I understand that I can revoke this Authorization at any time by communicating my desire to do so in writing.

_____ _____
Signature of Client Date

_____ _____
Signature of Client's Guardian or Legal Representative, as necessary Date

Notice to Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of person to whom it pertains, or as otherwise permitted by such regulations, a general authorization for the release of medical or other information is NOT sufficient for this purpose.

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POLICIES AND INFORMED CONSENT

This document describes the structure of therapy and provides for your informed consent if you choose to engage in treatment. This is a way to inform you about our therapy services. Please read and initial next to each policy and sign/date the last page of the document. Please discuss with me any questions that you may have about treatment.

_____ **Legal Rights:** All clients have the legal right to refuse services, seek other services, and address needs and or complaints via appropriate channels listed in the complaints/grievances section of this document.

_____ **Confidentiality:** All information disclosed within sessions, the written records pertaining to those sessions, are confidential. No client information will be released unless the client or guardian provides written consent. Due to disclosure required by law, possible exceptions to releasing confidential information include but are not necessarily limited to the following situations:

- Imminent danger to yourself or others,
- Abuse or neglect of a child or vulnerable adult,
- Legal matters in which information is subpoenaed by a court of law,
- Information requested by an insurance carrier responsible for providing mental health care service payment for those services (this is a major reason we do not bill insurance and not paneled by any insurance companies).

_____ **Consultation with the Parent or Legal Guardian**: If the client is a child (under the age of 18) may be an ongoing part of the treatment of a minor child. A parent and/or legal guardian can request information regarding their child's treatment. Such information will be provided with the knowledge of the child and, generally, at a summary level. It is often necessary for children to develop a "zone of privacy" from their parents/legal guardians in order to feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you are acknowledging that you are aware of this need for privacy as an important part of your child's treatment.

_____ **Health Insurance and Confidentiality Records:** Insurance companies may require basic treatment information and a mental health diagnosis Malott Counseling Services will not become involved in the ethically-gray area of being a part of "labeling" our clients with a diagnoses which becomes a part of the client's permanent healthcare record. This practice has been known to create difficulties for clients when such information affects them in terms of work, security clearances, legal issues, and many other areas once they have become identified with having a mental disorder. We also believe in the fundamental right of our clients to their privacy would be incongruent with the practice of divulging sensitive and possibly damaging information to insurance companies in order to be paid for services rendered. Most clients have discovered that our payments are very close to what their normal deduction would be without the possible danger of becoming labeled.

_____ **Treatment of Minors:** Malott Counseling Services will not treat a minor (person under 18 years of age) without the legal guardian's written consent. We do not provide custody evaluation recommendations, medical or prescription recommendations, or legal advice. These activities do not fall within our scope of practice.

_____ **Emergency Medical Care:** In the event of an emergency, I give Malott Counseling Services consent to seek emergency medical care on my behalf/minor child's behalf including administering first aid, CPR, medication, and contacting/informing emergency personnel including but not limited to 911 operators, ambulance, physicians, hospitals, and law enforcement services.

_____ **Office Etiquette:** We ask all client to be respectful, refrain from cursing, smoking, fighting, or bringing children (who are not involved in therapy) with them as we are not prepared for watching minors.

_____ **Payment Policy:** Payment for services must by handled before services are rendered. Malott Counseling Services accepts checks, money orders, credit/debit cards, and cash (exact change is appreciated) for payment of sessions.

_____ **Fee for Service:** Our fees are as follows:

- **$125.00 plus tax for initial session** which consists of paperwork and assessment necessary to determine a proper diagnosis and effective treatment plan.
- **$80.00 plus tax for all subsequent sessions.**

Our total fee can be compared closely with the normal deductible and co-pay of most insurance companies without the need to sacrifice the freedom of privacy. This protects you and allows us to maintain our integrity and dedication to preserving the moral values that we subscribe to.

_____ **Session Length:** Most sessions are scheduled to last 45-50 minutes with the remainder of the hour for therapist's documentation. Each session begins on the hour (unless otherwise mutually arranged in advance). Any sessions that extend past 60 minutes will be prorated at 10 minute intervals based on the current session rate.

_____ **Phone Calls:** Your therapist can be reached on the HIPPABridge App (the app can be found on google for laptops and in the app store for cell phones and tablets) for phone calls, emails, texts, and even video sessions under the name Zach Malott. I can take regular phone calls that do not involve sensitive information regarding your mental health care but I prefer the HIPPABridge App for two reasons:

1. It prevents any accidental violation of HIPPA regulations.
2. It protects your privacy at a secure level as required under HIPPA.

_____ **Between Session Emergencies:** Malott Counseling Services is not an emergency provider. In the event of an emergency, where there is imminent risk of danger to yourself or others, please call 911 immediately and/or go to your nearest emergency room. Once emergency services have been contacted, the situation has been defused, and you are safe – please inform us of the situation.

_____ **Grievances/Complaints:** You have the right to be treated ethically, professionally, and with respect. If you have any issues/complaints about your therapy, please discuss this with us as soon as possible so we can resolve the problem. I hold a bachelor's degree (BA) in Religion with a minor in Christian Counseling and a master's degree (MA) in Professional Counseling (60 hr. track) with a focus on mood disorders from Liberty University in Lynchburg, VA. I am licensed by the State of New Mexico as a Licensed Mental Health Counselor (LMHC), License # T-0185931 and Licensed as an Alcohol and Drug Abuse Counselor (LADAC), License # 0183151.

_____ **Case Consultations:** I utilize the services of Maurice Gudgel, an LPCC, License # 2493 in New Mexico, as a clinical supervisor for case consultation where necessary. During case discussions with this counselor, your privacy is protected because no files are examined and no identifying information (names, addresses, and phone numbers, etc.) other than the sex of the client is mentioned. All discussions are referred to as Jane or John Doe with a 4-digit number for case recognition and separation. Your initials above indicate that you have been made aware of these possible discussions (a third opinion where necessary) and agree to it.

_____ **Consent for Treatment:** I voluntarily agree to receive mental health services for __myself ___minor child. I authorize Malott Counseling Services to provide such services that are considered necessary and advisable. I understand

and agree that I will participate in the planning and treatment of my mental health services and that I may stop such services that I receive through Malott Counseling Services at any time. By initialing the appropriate places in this document and signing this Policies and Consent Form, I acknowledge that I have both read and understand all the terms and information contained in this document and asked any questions for clarification that I may have had. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ **Privacy Practices:** I have received, read, and have asked any clarifying questions about the Privacy Practices (separate document).

_____ **Questions:** If I have any questions about these policies or my therapy, I will let Malott Counseling Services know.

I have read and understand the above treatment agreement. I understand and have discussed any questions or concerns with my therapist. I consent to treatment.

_____ Date_____.
Client Signature

If it is my child entering treatment, I am the custodial parent or legal guardian of the child entering treatment and consent to have my minor child in treatment.

_____ Age_____
Child's Name

_____ Date_____
Parent/Legal Guardian Signature

In the case of shared custody requiring 2nd parent's consent:

_____ Date_____
2nd Parent/Guardian Signature

_____ Date_____
Zach Malott - Psychotherapist, MA, LMHC, LADAC

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Clients Rights and Responsibilities

We want you to be aware of your rights as a client of our service. The following is a summary of your rights based on the New Mexico law called the Patient's Bill of Rights. We have outlined these below, and invite you to ask your counselor if you have any questions about these rights. Following that, there is a list of your responsibilities to help us give you the best care we can.

I. Your Rights

1. Confidentiality: In the usual course of events, you have the right to keep your counseling here completely private. This means that, without your written permission, no information about your contact with MCS is available to anyone outside of MCS; However, there are certain exceptions, noted below, with which you should be aware before you enter a counseling relationship. Please read carefully through these exceptions, and be sure to ask your counselor if you have any questions.

Exceptions to Confidentiality

- If appropriate, your counselor may consult with your treating physician or other mental health provider to coordinate your care. However, in that event, your privacy will be protected by not using names or any other identifiable information;
- If you pose a threat of harm to yourself, to another person, we will take whatever steps are required by law, or permitted by law, to help prevent the potential harm from happening. This may include contacting your family and/or proper authorities;
- In the event of a psychiatric hospitalization;
- If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect as required by the State of New Mexico;
- A court order, issued by a judge, could require us to release information contained in your records, or could require a therapist to testify;
- If you have been mandated by a court of law to be evaluated.

2. Release of Information: You have the right to discuss with your counselor what information is in your record, and if you sign a release of information authorizing MCS to share information with outside sources, you have a right to discuss specifically what information will be released.

3. You have the right to end your counseling at any time.

4. You have the right to request a different counselor to the extent possible if you are dissatisfied with me. A referral will be assisted if the need occurs.

5. You have the right to obtain an evaluation for the issue that brings you here. If we are unable to be of help, we will make every effort to refer you to appropriate outside treatment.

6. You have the right to be informed about the services available to you here, and, unless it is an emergency, to participate in the process of deciding whether to utilize these services.

7. You always maintain the right to question the focus of your sessions;

8. You have the right to know the credentials of your therapist;

9. You have the right or to ask for a second opinion.

10. You have the right to present a complaint, knowing that your care will not be compromised in any way. If you have a problem concerning your care, that you cannot solve with me, fill out a complaint form with the New Mexico Boards and Commissions Department at the following PDF: http://www.rld.state.nm.us/uploads/files/Complaint%20Form%20(Revised%2008_2015)(3).pdf

You can check with the board at the following number to check on the status of a claim at 505- 476-4622.

II. Your Responsibilities

1. Keep your scheduled appointments and let us know as soon as possible if you cannot keep one.

2. Be as honest and open as possible with your counselor.

3. Between sessions, think through the concerns you are addressing in counseling.

4. Follow through on treatment recommendations and complete your counseling homework assignments.

5. We ask that you end your work with us in a termination session, rather than not keeping your appointment. This way you can share and discuss with your counselor what was useful and what could have been improved.

6. If you feel that you might harm yourself or others, go directly to the ER at Lincoln County Medical Center (LCMC) or call 911.