



Welcome to Eastside Counseling & Coaching!

Personal Bio. Mrs. Hollomon received her Masters of Arts in Mental Health Counseling from Liberty University in Virginia, after undergraduate studies from University of Northern Colorado in Communication. She is a Licensed Professional Counselor and a Certified Professional Coach. Michelle's work with couples and individuals is extensive and varied, encompassing the treatment of the difficult challenges facing people today. These challenges include couples conflict, depression, anxiety and issues related to spirituality. While living in Germany, Michelle worked in a children's clinic providing play therapy and parent education workshops, in cooperation with the United States Air Force 52nd Medical Group. She also provided counseling for Active Duty Members and their families. After returning to the US, Michelle was selected as a fellow with Pastoral Counseling and Education Center in Dallas, TX focusing energies on the integration of counseling therapy and Judeo-Christian spirituality. Her specialty is treating stress and anxiety, and interpersonal relationships. She is a member in good standing with American Association of Christian Counselors and is married with two children.

Disclosure Statement & Informed Consent

Nature of Counseling. Counseling is a relationship between the therapist and client; whereby trust is the fundamental premise. The therapist's role is to provide understanding, compassion, and challenge for change; accepting and valuing the client. The client's role is to be a partner in the change process, to work toward his/her goal, and to be committed to his/her own growth. _____ (Initial Here)

Confidentiality. Your relationship with Michelle Hollomon is important and confidential. Information cannot be released regarding your counseling without your written consent unless disclosure is required by state law.

- In the event of a medical emergency, emergency personnel or services may be given necessary information.
- In the event of a threat to harm oneself or someone else, if that threat is perceived to be serious, the proper individuals must be contacted. This may include the individual against whom the threat is made.
- In the event of suspected child or elder abuse, the proper authorities must be contacted. The actions do not have to be witnessed to be reported.
- If ordered by a judge or other judicial officers, information regarding the client's treatment must be disclosed.



- e) If the client brings a complaint against me with the State of Washington, Department of Health, client information will be released.
- f) If an attorney in the State of Washington subpoenas records, they will be released unless the client files a Protection Order within 14 days of the subpoena.
- g) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.
- h) In the event the client reveals the contemplation or commission of a crime or harmful act, the therapist may release that information to the appropriate authorities.
- i) In the case of a client who is a minor, information indicating that the client was the victim of a crime may be released to the proper authorities. _____ (Initial Here)

The client understands and agrees that the therapist's working notes are not considered part of the clinical record and will not be released to the client or to any other persons, agencies, or organizations under any circumstances. The client understands and agrees that any records obtained from other therapists, agencies, or institutions also will not be released by the therapist under any circumstances. The therapist will respond to any court order for records by providing only the dates of treatment or contacts with the client and a general summary of psychotherapy/counseling activity. The therapist will have broad discretion to release any information he deems relevant in situations where he believes the client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

Part of providing quality care is respecting your privacy rights and maintaining confidentiality of all your records pertaining to therapy. Eastside Counseling and Coaching will not use or disclose your health information for any purpose not described in this notice without your written authorization.

_____ (Initial Here)

Unprofessional Conduct. If you suspect unprofessional conduct, contact the Department of Health at the following address and phone number:

Department of Health, Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869
360.664.9098



Fees: Fees are discussed before or during your first session. The standard fee for a 50-minute session is \$115.00. You are asked to pay at the time service is rendered. Mrs. Hollomon does not accept insurance but will provide you with receipts for you to file with your insurance company if you chose to do so.

I agree to pay Eastside Counseling and Coaching at the rate of \$115 per 50-minute session. Initials _____

If Mrs. Hollomon is requested by her client or subpoenaed by any attorney to testify in any court-related proceeding as a result of the therapeutic relationship, she will produce the requested information because she is required to do so by law. Mrs. Hollomon may be required to show the court her records and/or testify in court. The client will be required to reimburse Eastside Counseling & Coaching in advance at the rate of \$230/hr for the following applicable records: production of any form or report pertaining to records, preparation/review time concerning depositions, preparation time for court, travel time to/from depositions and court, waiting time at deposition and court, time in deposition and court. There is also a retainer fee of \$2000. **I have read the previous statement and agree. Initials _____**

Cancellations: Sessions are generally scheduled for 50 minutes. The appointment is reserved for you. You will be billed the full amount for missed appointments and cancellations of less than 24 hours notice. If Mrs. Hollomon is not available to take a call, you may leave a confidential voice mail at 425-999-9470, which will be time stamped for delivery verification. Please do not e-mail notification of cancellation or rescheduling. After two consecutive absences, Mrs. Hollomon may, at her discretion, refer you to another counselor.

I agree to pay for missed scheduled appointments if I do not give at least 24 hours notice by phone of my wish to cancel or reschedule. Initials _____

Counseling Relationship: During the time you work together with Mrs. Hollomon, you will meet regularly for approximately 50 minutes per session. This is the time you will be billed for. Mrs. Hollomon sometimes does allow consultation by phone for short amounts of time; however, time in excess will be billed. Although our session may be very intimate psychologically, we have a professional relationship, not a social one, as a social relationship might lead to exploitation of clients and impair objectivity in the professional role. Mrs. Hollomon's services will be rendered in a professional manner consistent with accepted legal and ethical standards. If you have problems with your counseling relationship, it is encouraged that you speak directly with your counselor. While benefits are expected from counseling, specific results are not guaranteed. As a client, you have the power to refuse or discuss modification of any of her counseling techniques or



suggestions. Both the client and Mrs. Hollomon have the right to withdraw from the therapy process. If the counseling process is withdrawn from, Mrs. Hollomon will provide appropriate referrals upon the client's request. Therapists are expected to provide services to clients only within the boundaries of their competence. They are also expected to acknowledge, be sensitive to, and respect the diversity of values, attitudes, opinions, and culture of clients and to avoid engaging in any behavior that is discriminatory, harassing, or demeaning to others. **Initials**_____

Effects of Counseling. At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and /or your understanding of yourself. Some of these changes may be temporarily distressing. The exact nature of these changes cannot be predicted. Together, you can work with your therapist to achieve the best possible results for you. **Initials**_____

Emergency/Crisis Situations. Your counselor has voice mail at 425-999-9470 if you need to get in touch with her. Mrs. Hollomon does **not** provide a 24 hour crisis counseling service. If in a life threatening situation, *always* call 911 before contacting your counselor. You may also contact the Crisis Hotline # at: 800.244.5767 or 206.461.3222 . Please notify Mrs. Hollomon if an "after hours emergency" has occurred so that a follow-up session may be scheduled if as soon as possible. **Initials**_____



Consent to Treat

I do hereby seek and consent to take part in the confidential treatment by Michelle Hollomon, MA, LMHC, CPC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that after the final session or in the event that I have not attended a therapy session in three months that the client/therapist relationship will be considered closed unless I initiate further contact. I understand I have the right to refuse treatment at any time. **Initials** _____

*Your signature here indicates you have read, understand and accept this document (**Disclosure Statement and Informed Consent Policies**) and that any questions you had about this document were answered to your satisfaction, and that you were furnished a copy of this document. By your signature, you issue consent for Mrs. Hollomon to provide counseling, you understand you financial obligations and acknowledge your commitment to conform to these documents specifications.

Print Name _____ Fee _____

Client Signature, Parent/Guardian _____ **Date** _____

Client Signature, Parent/Gaurdian _____ Date _____

Counselor Signature _____ Date _____

Michelle Hollomon, M.A., LMHC



Client Information Form

Personal Information:

Child's name: _____ Today's Date: _____

Date of Birth: _____ Address: _____

Home Phone: _____ Mom's Cell Phone: _____ Dad's Cell Phone: _____

Where would you prefer to be called? _____ E-mail: _____

Mother's Occupation and Where: _____

Father's Occupation and Where: _____

Religious Faith: _____ Church: _____

Is your religious faith something you would like to talk about? _____

Please List Your Children.

Name	Gender	Age	Comments

Who is currently in your household. _____

Please list any medications that your child is taking:

Any emergency names and numbers besides you: _____

Please describe your child's personality: _____

Please describe your child's interests: _____



Please circle any difficulties that have applied to your child in the past or do apply currently.

- Engaging Peers
- Hyperactive
- Academic Trouble
- Animal Cruelty
- Immature
- Threats
- Lack of Attachment
- Poor Concentration
- Very Shy
- Nervous Tics
- Fearful or Anxious
- Substance Abuse
- Temper Tantrums
- Tolerating Separation
- Bed Wetting
- Violent Temper
- Assault others
- Bizarre Behavior
- Frequently Tearful
- Often Sad
- Breaks Things
- Dominates Others
- High Intelligence
- Nightmares
- Phobias
- Problems with Authority
- Playing Cooperatively
- Forgetful
- Fire Setting
- Non-Compliant
- Self-injurious
- Frequently Daydreams
- Easily Distracted
- Isolates Self
- Biting Fingernails
- Learning Problems
- Night Terrors
- Associates with Acting-Out Peers
- Sibling Rivalry

Other: _____

Please name Child's ethnicity: _____

Please describe any cultural issues that contribute to current problem: _____

Please describe your parent style: _____

Please describe any current stressful situations that you think has caused problems for your child.

Please list any additional information that you think would be helpful. _____



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