ILENE CRYSLER BOSSCHER, LMFT-S, LPCC-S, RPT-S

IBOSSCHERTHERAPY.COM

502.552.7319

CLIENT INFORMED CONSENT & DISCLOSURE STATEMENT

Welcome to My Private Practice!

This paperwork has been prepared to inform you and provide you a brief orientation of the following:

My qualifications as a therapist
What you can expect of me as a therapist
Your rights as a client
Policies and procedures of my practice that will guide you in this therapy process.

We will be going through this paperwork in our initial session called an Intake Session as we begin together the therapy process. You will receive and keep this copy and I will keep a copy to start your record file. Please feel free to ask me any questions or discuss any concerns with me at any time today or in the future. I welcome the opportunity to clarify or explain anything to you.

My Academic Education

Completed:

~Master of Arts in Counseling from The Assemblies of God Theological Seminary, 2003. ~Master of Divinity in Theology from The Southern Baptist Theological Seminary, 2007. ~Post-Graduate Certificate in Play Therapy from MidAmerica Nazarene University, 2012

In Process:

I am currently a Doctoral Candidate in the Doctor of Philosophy degree in Marriage and Family Therapy at Amridge University.

My Certification Trainings Beyond Academic Centers

~Theraplay Institute, Level Two, 2011.

~The Gottman Method, Level Three, 2012.

~Emotionally Focused Therapy, Externship, 2014.

~Imago Relationship Therapy, 2015.

~Havening Techniques,"2017

~Bessel van der Kolk's Trauma Course, 2021

My Philosophy of Therapy:

I am a Solution-Focused Therapist, which means that from the beginning of our time together I am helping you look for what is working for you as well as what is not. We will celebrate everything what is working well for you, but our focus will be on what you identify is not working well for you in your life. The goals that we will set will reflect this focus. Something to keep in mind is that we need to be working together. You know the unique information about yourself and what is not working for you, and I know how to address change and the action steps to make that a possibility. We will work together to change what needs to be changed in your life. One of the elements of this theory that I love is that it is client centered not protocol centered. Therapy is about change and since how everyone needs to change is unique to them, I believe this is an effective way to discover that.

Your Rights as a Client:

- You have the right as a client to know and understand any procedures, methods, techniques, and time involved in therapy.
- I consider you an expert about yourself. I do not know any of your details until you inform me.
- You should also be aware that as you engage in therapy those discussions of memories and current situations maybe upsetting to you and cause you pain. This is not usual. Many people feel worse before they feel better as they move through their therapy.
- I believe that it is best for us to have an ending session before termination so that I can provide you with a summary of what we have accomplished and what if anything needs additional therapy sessions.

I need to follow the guidelines from two different sources:

1) **Professional Ethics** of a Licensed Marriage and Family Therapist/ Licensed Professional Clinical Counselor:

I would like to note about one aspect of the AAMFT Code of Ethics concerning our relationship as client and therapist. Our relationship is a professional therapeutic relationship not a social, business, or romantic relationship. Sexual intimacy between a therapist and client is never appropriate. it.

2**) The Laws** of The State of Kentucky and sometimes the Federal Government have laws that need to be followed concerning the confidentiality of our relationship:

I am a mandated reporter by the State of Kentucky and therefore there are certain situations where I am required by law to break your confidentiality and reveal information obtained during therapy without your permission. These situations are: If you threaten bodily harm or death to yourself or another person, If a court of law issues a legitimate court order that is signed by a judge, If you reveal information relative to the past or present physical abuse, sexual abuse, or neglect of a minor who is under 18 years of age. or elder, If you are in therapy by an order of a court of law, If you are involved in a criminal or delinquency proceeding.

Policies and Procedures of my Practice:

Appointments:

- Appointments must be canceled or rescheduled 24 hours in advanced of the scheduled appointment to avoid being charged for the appointment at the rate that would apply to the length and type of appointment that was agreed upon.

My Standard Fees:

- For individuals, couples, families, or groups of 2 or more: $135.00 per 45-minute therapy session.
- For a list of additional services provided please ask.
- The Formal Intake Process could include some of the following:
  - Orientation to Practice
  - Client Reported History and Current Situation
  - Genogram
  - Events Timeline
  - Client Goal Setting and Prioritizing of Them Assessments
- I require payment for the sessions at the end of the session and I do not keep accounts receivable. I accept major credit cards, Health Saving Account Debit Cards, Flexible Spending Debit Cards, PayPal, and Venmo.
- Please note: to continue in therapy with me, I need to see you a minimum of one session per month.

Assessments:

- When diagnostic testing is appropriate and recommended, the costs for such testing are in addition to the session fee described above. The costs vary depending on the test.

Test	Cost
Gottman	$140.00 per couple
Prepare/Enrich	$100.00 per couple
Taylor-Johnson Temperament Analysis	$50.00 per Individual test
Taylor-Johnson Temperament Analysis	$200.00 per couple (4Tests)
Parent/Child MIM	$135.00 per session

Method of Payment:

- We/I plan on paying for our/my therapy with this method of payment:
- HAS/FSA/Credit/Debit Card number____
- Expiration Date_______________ CVV_______________Zip code__________________

AFFIRMATION OF CLIENTS TO PARTICIPATE IN THERAPY

I (We) affirm that I have gone over all of the above with Ilene Crysler Bosscher, MA, MDiv, LMFT-S, LPCC-S, RPT-S and that I (We) understand the facts presented therein. I (We) have asked for clarification or further explanation where it was unclear.

I (We) consent to participate in evaluation and treatment and that my signature below affirms my voluntary consent to receive therapy.

Name of Client Signature of Client Date

____

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Name of Client Signature of Client Date

Signature of Ilene Crysler Bosscher, MA, MDiv, LMFT-S, LPCC-S, RPT-S Date

Your Current Contact Information:

Street Address

City State Zip code

Email Addresses that you would like me to contact you at.

Work, and cell phone numbers that I may contact you at.

Cell____

__

Is it ok for me to leave a text message on your phone?
____

SOLUTION FOCUSED BRIEF THERAPY HOMEWORK

For The Second Session

The theory of Solution Focused Brief Therapy considers you, the client to be 'an expert' on yourself. Who better to know you and your situation than you! To develop your Solution Focused Goals, think about these questions, note your thoughts and when you come back for the second appointment be ready to discuss them. We will turn what isn't working well into goals of your therapy.

What is working well for you?

What is not working well for you?

The Theory's Miracle Question: If you woke up tomorrow and your life was without what wasn't working for you in your life, what would your life look like?

GOALS

FOR THE SECOND SESSION

1.

2.

3.

4.

5.

ILENE CRYSLER BOSSCHER, MDIV, MA, LMFT-S, LPCC-S, RPT-S
ADVANCED SOLUTIONS COUNSELING AND PLAY THERAPY CENTER, PLLC
Advancedsolutionscc@gmail.com 502.552.7319

RELEASE OF INFORMATION

When this form is filled out, completed, and signed this form authorizes the release of, and addition to, information that I contained in your clinical record to and from the person or persons and or organizations designated.

The purpose of the disclosure is:

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Name(s) of Client(s)
Date or Dates of Birth

Authorization is hereby granted to Ilene Crysler Bosscher, MA, MDIV, LMFT-S, LPCC-S, RPT-S to release and or obtain the information specified below to and or from:

____
__ Name, Title, Organization

____
__Address

____
__

City, State, Zip code Phone

Information to be released and/or requested is checked below:

Assessment_____	Treatment Plan_____
Psychosocial Evaluation_____	Dates of Treatment_____
Psychological Evaluation_____	Diagnosis_____
Psychiatric Evaluation_____	Progress Report/Attendance Reports_____
Medical Reports______	Termination/Discharge Summary_____

Court Records______	Other____________________________________
Complete Chart______	Other____________________________________
Consultation_____	Other____________________________________

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I understand I have the right to revoke this authorization in writing at any time by sending such written notification to the address above. I also understand that my revocation will not be effective to the extent that Ilene Crysler Bosscher, MA, MDiv, LMFT-S, LPCC-S, RPT-S has acted in reliance on this authorization. I also understand that Ilene Crysler Bosscher, MA, MDiv, LMFT-S, LPCC-S, RPT-S may not condition therapy upon my signing an authorization unless the therapy is provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of the information, and therefore will no longer be protected by the HIPAA Privacy Rule, unless revoked as described above this consent will expire_____________.

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Signature of Client Date Signature of Client's Guardian

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Signature of Client Date Signature of Client's Guardian

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Witness Date Relationship to Client