Layne Dillingham
LICENSED COUNSELOR

Client ID#:_____

Layne Dillingham M.S., LPC
849 E Fairview Ave
Meridian, ID 83642
661-859-9336

Informed Consent

Welcome to my practice. This document contains important information about my professional services and operating policies. It is intended to clarify your rights and responsibilities as a client and my rights and responsibilities as a counselor. There are also certain legal limitations to those rights of which you should be aware. If you have any questions regarding these policies, please feel free to ask me for more information. Once signed, this document will represent a binding agreement between us as well as your consent for us to begin counseling.

Counseling Services

The counseling process is a partnership between client and counselor to work on mental health, relational, and wellness goals. There are many different methods I may use to address the particular problems you hope to focus on. Counseling is not like a medical doctor's visit. For it to be most successful, active participation on your part is needed. You will need to work on things we talk about both during our sessions and between meetings.

Counseling can have both risks and benefits. Participation in counseling can result in emotional discomfort; some clients temporarily feel worse before they improve. Counseling is a unique and highly individual experience. Outcomes cannot be guaranteed, and some clients find that participating in counseling results in changes they didn't expect when they started the process. While these risks exist, counseling has been shown to have many benefits for those who choose to participate. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. It may add a new perspective on a set of challenges. My highest priority as I support you in achieving your goals is to keep you safe, both physically and emotionally.

Our first sessions will involve evaluating your needs and developing a treatment plan to follow during our work together. I encourage you to utilize this time and information to determine whether you feel comfortable working with me. Throughout the course of therapy, should I assess that I am not equipped with the proper tools to lead to your success, I will discuss this with you and, if appropriate, terminate treatment. I will provide referrals to other practitioners whom I believe are better suited to help you if you so desire. Success in therapy depends upon many factors, including what your specific goals are, your willingness to actively participate in therapy, your commitment to change, and the therapeutic relationship you and I develop.

I graduated with my master's degree in Counseling on the Marriage, Couple, and Family track from Northwest Nazarene University, which was preceded by my undergraduate degree from Boise State University in Business Administration. I am an LPC (Licensed Professional Counselor) by the state of Idaho. My license number is LPC-8171. While I do use a variety of approaches as appropriate in counseling, I mainly operate from a Family Systems approach. This

model, essentially, views individuals as part of a larger system that has influence on the way they think, feel, and behave.

Counseling with me is voluntary, and you may terminate the relationship at any time. You have the right to be involved in treatment decisions, refuse treatment or recommended services, seek second opinions, and file a complaint without retaliation. I do not discriminate against clients in any way, including based on race, ethnicity, gender, age, or sexual orientation.

Below are the types of counseling services I offer:

_____ Individual Therapy- One individual person is the client. If the client is under 14 years old, consultation with guardian(s) may take place as part of treatment, but the individual remains the client.
_____ Couple Therapy – The relationship between the couple is the client and we work towards partnership goals, not individual goals.
_____ Family Therapy – The family system is the client, not any individual.

I cannot guarantee confidentiality in counseling involving more than one client, because I cannot control what the other person might share outside of our sessions. I can guarantee that I will uphold confidentiality on my end.

The Counseling Relationship

The clinical relationship is a professional, genuine relationship that allows for client growth to occur. Because the focus is on the client, the relationship is different than a friendship. I value the boundaries of the counseling setting and will not pursue a personal or non-counseling professional relationship with a client or former client. I do not accept gifts or barter services. Sexual intimacy between a clinician and client is never appropriate and should be reported to the Idaho Licensing Board of Professional Counseling and Marriage and Family Therapists. I hold the right to immediately terminate the counseling relationship if my family or I am threatened or in the event of a lawsuit.

Diagnosis and Testing

I may make a diagnosis of a mental disorder, if necessary, during our time as counselor and client. I take precautions to determine a proper diagnosis to the best of my abilities, and you are always welcome to obtain a second opinion. I will communicate with you what a diagnosis means. I may also refrain from making a diagnosis if I determine it could cause harm to you or others. I may conduct testing as part of this process. I only conduct testing I have been trained in, and I will discuss with you the intended use for any testing that is done. I do take a client's cultural background into consideration when making a diagnosis or reviewing test results. You are invited to ask any questions you have about a diagnosis or testing.

Meetings

Sessions are typically 45-55 minutes, and only by appointment. Most often, my sessions take place on a weekly basis, but frequency and duration may vary depending on your needs. If you are more than 15 minutes late, we will not be able to meet. If you are late for a session, we will

still end on time and you will be charged for the full session. If you need to cancel or reschedule an appointment, I am available during business hours. You may contact me at (661) 859-9336. I do not provide a 24-hour crisis line. If there is an emergency needing immediate attention, you may call 911 or go to a local emergency room.

Cancellations and Rescheduling

I ask for a minimum of 24 hours advanced notice if you cannot keep a previously scheduled appointment. This courtesy allows me to plan my schedule effectively and accommodate other client requests.
If you cancel or reschedule less than 24 hours before your appointment time you will incur a Late Cancellation Fee of $20 due before your next appointment. If you "no show" to an appointment (you do not call to let me know that you are unable to make your appointment, and do not come for the appointment) I charge a "No Show" fee of $20 due before your next appointment. Please note that after 3 missed appointment times, your scheduled sessions may no longer be reserved for you.

Fees and Payments

My counseling rates are not flexible due to insurance laws. Payment for services is due at the time of session. If a third party is being billed, you are responsible for any co-payment amounts at the time of session. If a session runs longer than the allotted time, I will charge accordingly. I have the right to terminate counseling services if payment is not made. My current rates are listed below:

Counseling Session (45 Minutes) …. $100.00
Counseling Session (55 Minutes) …. $120.00
Check-in Session (10 minutes) …. $25.00

Insurance and Third-Party Reimbursement

Please contact your insurance company to find out their limits of coverage for mental health services. Once you have contacted them, I will submit claims to your insurance. It is your responsibility to stay current with your insurance, including alerting me if you become uninsured. You agree to pay all co-payments as required by your insurance. Your insurance may request certain information. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company.*** If a church or Bishop is funding your counseling, they may request certain information. ***You understand that, by using these services, you authorize me to release such information to your church leader or Bishop.*** You are financially responsible to me for all charges, including unpaid charges by your insurance company or any third-party payor.

Contacting Me

You may contact me for scheduling purposes by calling or texting me at (661) 859-9336. I do have a secure voicemail, but I cannot guarantee the confidentiality of text messages. While I do try to be prompt at getting back to clients during business hours, I cannot guarantee a response time. Email correspondence, by nature, is not confidential despite security measures. Should this

be your preferential means of communication, you may email for scheduling purposes only at ldillingham.counseling@gmail.com. I do attempt to limit the correspondence above to scheduling purposes to reserve content discussions for our sessions. For this reason, you will be charged a prorated amount based on your regular session fee for phone calls exceeding 10 minutes. I do not provide a 24-hour crisis line. If there is an emergency needing immediate attention, you may call 911 or go to a local emergency room.

Emergencies

If you are experiencing a life-threatening emergency needing immediate attention, please call 911 or your local hospital emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality

As a counselor in the state of Idaho, I take every reasonable precaution to protect your right to privacy by following the Code of Ethics created by the American Counseling Association. I hold the information we discuss in counseling strictly confidential and will not release this information without your prior written consent. Please be aware, there are some exceptions to this confidentiality in which I may need to report without your permission. These exceptions are:

- Suspicions of abuse or neglect to a child, elderly adult, or disabled person, including past and present
- If you threaten serious bodily harm to another person
- If you give strong indication that you are likely to seriously harm yourself
- Administrative staff may have access to some of your information in order to tend to billing. They are held to the same level of confidentiality as I am.
- At times I need to consult with a college for a second opinion or to determine the best course of action. I will not use your name in these consultations unless I have your written consent.
- Licensing Board proceedings
- Continuing supervision with a State Certified Supervisor held to the same level of confidentiality
- I will protect your provided information in court, in general, unless a judge orders me to do otherwise. However, I do reserve the right to share confidential information in the event I am defending myself in a lawsuit brought on by the client.
- Parents legally have the rights to counseling records of a client under the age of 14.
- If you are participating in couples or family counseling, do not share any information with me that you would like to be kept a secret from another individual who is also partaking in the sessions. I am not a secret keeper in the best interest of the couple.
- If you give written permission for me to provide or request information from another person or agency

Record Keeping

I keep records and notes about our sessions to track progress towards your goals for seven years. These records are kept in a locked file cabinet where they are secure. You may request a summary of the records at any time unless I believe that doing so might be harmful in some way.

You also have the right to request these records be sent to another professional or third party, but I will need a signed Release of Information document before I can comply. In the event of your death, your records may be released to your legal representative upon the request of your probate attorney, executor, or family member. Although I will still uphold confidentiality on my end, I will not be able to guarantee the confidentiality of your records once they have been sent to a third party.

Client Grievances

If you are unsatisfied with your counseling experience, please communicate your concerns with me. You can also contact the Idaho Board of Licensure which regulates my status as a counselor to file a formal complaint. You can do this online by following the instructions listed at www.ibol.idaho.gov or by calling 208-334-3233. Their address is 11351 W Chinden Building 6, Boise, ID 83714. I agree to not retaliate against you or discourage you from expressing a complaint. Disclosure: licensure under the Idaho chapter does not imply endorsement by the licensing board nor effectiveness of treatment.

Minors

In order to authorize mental health treatment for a child, you must have either sole or joint legal custody of the child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child. If either parent decides that therapy should end, I will honor that decision, however, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

In the course of my treatment with your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my client is your child – not the parents/guardians nor any siblings or other family members of the child.

Minors do not legally hold the same right to confidentiality that adults do, but they ethically deserve this privilege. Counseling is most effective when the client feels comfortable that the information they are sharing isn't going to reach others. It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. However, if your child's risk-taking behavior becomes serious, I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you. The same limits of confidentiality that apply to adults apply to children. Please see the confidentiality section above.

Although the laws of Idaho do give parents of clients under 14 years old the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records. In addition, you have the right to request the release of information regarding your child's case notes to other parties if your child

is younger than 14. If you wish for me to release your child's information, please submit a written release of information form.

Legal Issues, Custody Evaluations and Fees

If I am required to appear as a witness or to otherwise perform work related to any legal matter, the party issuing the subpoena agrees to reimburse me at the rate of $250.00 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. ***I do not perform custody evaluations.***

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Again, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party issuing the subpoena agrees to reimburse me at the rate of $250.00 per hour.

TeleHealth Services

At the beginning of each Telehealth session, you will be asked to verify your current location and whether anyone else is in the room. You are responsible for finding a location that is free from distractions or intrusions. Neither party is permitted to record the sessions without the other party's consent.

Agreement

I have read and agree to the information in this contract. I understand my rights and responsibilities and agree to the conditions outlined.

Print Name	Client Signature	Date
Print Name (Parent, guardian, or spouse)	Client Signature (parent, guardian, or spouse)	Date
Print Name	Counselor's Signature	Date

Layne Dillingham
LICENSED COUNSELOR

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective June 4, 2021

Information is only released in accordance with state and federal laws and the ethics of the counseling profession. This notice describes Layne Dillingham Professional Services LLC's policies related to the use and disclosure of clients' healthcare information.

Use and disclosure of protected health information for the purposes of providing services.
Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT Use and disclose health information to:
I will use and disclose your personal health information to provide, manage, and coordinate your care and related services. This includes consulting with third party providers and providing referral sources.

PAYMENT Use and disclose health information to:
Your personal health information will be used, as needed, to obtain payment for services provided. Examples of this include disclosing personal health information to your insurer to obtain reimbursement for your healthcare. Verifying insurance and coverage, processing claims, and collecting fees are part of this process.

HEALTHCARE OPERATIONS Use and disclose health information for:
Healthcare operations are activities that are related to the operation of this practice. Examples include the review of treatment procedures, review of business activities, certification, staff training, and compliance and licensing activities.

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT
Other instances in which your personal health information may be used or disclosed without consent are emergencies, criminal damage, those required by law, judicial and administrative proceedings, health oversight, audits, appointment scheduling, workers compensation, treatment alternatives, and mandated reporting situations. Mandated reporting situations include abuse of a child, elderly adult, or vulnerable adult. Mandated reporting situations also include an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person with a plan to carry out the threat or a plan and method communicated for ending one's own life.

CLIENT RIGHTS:

Right to request where we contact you

- Home yes or no
- Work yes or no
- Cell phone yes or no
- If not, how may we contact you _____

Right to release your medical records

You have the right to make written authorization to release records to others. You also have the right to revoke this release in writing. Revocation is not valid to the extent that I have acted in reliance on such previous authorization.

Right to inspect and copy your medical billing records

You have the right to inspect or obtain a copy of your personal health information in your mental health and billing records used to make decisions about you for as long as the information is maintained in the record. The counselor may deny your access to information under certain circumstances, but in some cases, you may have this decision reviewed. The requesting party may be charged reasonable, cost-based fees incurred for the cost of copying, printing, mailing, etc.

Right to add information or amend your medical records

You have the right to request an amendment of personal health information for as long as the information is maintained in the record. The amendment request must be made in writing. The counselor may deny your request and will let you know why in writing within 60 days of receiving the request. If this request is denied, you have the right to file a disagreement statement. The disagreement statement and my response will be filled in the record.

Right to Accounting of disclosures

You have the right to receive an accounting of disclosures I have made regarding your personal health information in the past six years. Exceptions include disclosure for treatment, payment or healthcare operations, disclosures pursuant to a signed release, disclosures made to you, and disclosures for law enforcement. I respond to requests for disclosures within 60 days of receiving them.

Right to request restrictions on uses and disclosures of your healthcare information

You have the right to request restrictions on certain uses and disclosures of protected health information about you. These requests must be made in writing. However, the counselor is not required to agree to a restriction you request.

Right to complain

If you have questions about this notice, disagree with a decision that has made about access to your records, or have other concerns about your privacy rights, please contact me first: Layne Dillingham MS, LPC. at (661) 859-9336. If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to Layne Dillingham, MS, LPC., 849 E Fairview Ave. Meridian, ID 83642. If you are not satisfied, you may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave S.W. Room 509F HHH Building, Washington, D.C. 20201 or at OCRComplaint@hhs.gov. You have specific rights under the Privacy Rule. I will NOT retaliate against you for exercising your right to file a complaint.

Right to receive changes in policy

I reserve the right to change the privacy policies and practices described in this Notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If a revision of policies is made to these policies and procedures, I will have the revised copy of the Notice available for your inspection. Requests can be made to me via writing. My office is located at 849 E Fairview Ave. Meridian, ID 83642.

Please verify below you have received a copy of the HIPAA Notice of Privacy Practices and understand your rights.

Print Name	Client Signature	Date

Layne Dillingham
LICENSED COUNSELOR

Client Information (Adult)

Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will kept strictly confidential and released only in accordance with professional ethics and applicable law.

Date _____ Referred by_____

Name(s) _____ □ M □ F □ Other _____

Preferred Name: _____ Birth Date___/___/___

Spouse/Partners Name_____ □ M □ F □ Other _____

Birth Date___/___/___

Preferred Pronouns: _____

Relational Status: (Please Circle) Years in this relationship _____

Married Cohabitating Separated Divorced Widowed Single Engaged

Children's names/ages_____

_____

Others living in your home _____

Address _____

Street Apt.# City Zip

Home phone _____ May we leave a message? □ Yes □No

Cell phone_____ May we leave a message? □ Yes □No

Email: _____ □ Yes □No

May we email for appointment reminders or any non-treatment related information?

Best way to reach you? □ Home Phone □Cell Phone □ Email

Are you currently employed? □ Yes □ No

If yes, what is your job? _____ Employer_____

Describe your personal strengths _____

_____

Describe your support system (Family, Friends, Church, etc.) _____

_____

Would including spirituality in your counseling be helpful? □ Yes □ No

If yes, what is your religious or spiritual preference? _____

Emergency Contact _____

Name Relationship Phone

Are you currently receiving counseling? □ Yes □ No Counselors Name_____

Ethnicity (Check all that apply)
□ American Indian/Alaskan Native
□ Asian
□ Black/African American
□ Hispanic/Latino
□ Multiracial
□ White/Caucasian
□ Prefer not to answer

Highest Level of Education Completed
□ High School □Other _____
□ GRE
□ Some College
□ Associate's Degree
□ Bachelor's Degree
□ Master's Degree
□ Doctorate or Equivalent

Current Concerns (Check all that apply)

□ Depression	□ Career	□ Spiritual Issues
□ Anxiety/Stress	□ School	□ Trauma
□ Relationships	□ Grief	□ Finances
□ Eating Issues	□ Anger	□ Health
□ Life Transitions	□ Abuse	□ Insecurity
□ Substance Abuse	□ Family	□ Sexuality
□ Divorce	□ Parenting	□ Suicidal Thoughts
□ Discrimination/prejudice		□ Other

What are the main concerns for which you are seeking counseling? _____

_____

On a scale of, 1 (mild) to 5 (Severe), how distressing are the issues for you? 1 2 3 4 5

How long have these issues been a concern? _____

What are your goals for counseling? _____

_____

Have you received counseling in the past? □ Yes □ No

Counselor's Names(s)/time frame _____

What were the issues and was the counseling helpful? _____

_____

Medical Information

Physician's Name _____ Phone_____

Current medical conditions _____

Hospitalizations/major illnesses in the past 5 years (physical or mental) _____

_____

List medications and vitamin/herbal remedies taken regularly. Indicate dosage and purpose:

_____

_____

Layne Dillingham
LICENSED COUNSELOR

Credit Card Payment Authorization Form

Please sign and complete this form to authorize Layne Dillingham Professional Services LLC to apply charges to your debit/credit card listed below.

By signing this form, you give Layne Dillingham Professional Services LLC permission and authorization for the following:

Permission for my credit card to be charged *following client(s) session*

Please complete the information below:

I _____ authorize Layne Dillingham Professional Services LLC to charge my
full name

debit/credit card in the amount of

$_____ for payments related to counseling services for _____.
session fee client(s) name

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: Visa MasterCard Discover American Express

Cardholder Name _____

Card Number _____

Expiration Date _____

CVV2 (3 digit number on back of card) _____

SIGNATURE_____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company; so long as the transaction corresponds to the terms indicated in this form.