the workout couch
WHERE THERAPY MEETS HEALTH

Mission Statement
To create an environment that enables and motivates personal growth both physically and mentally in an educational, holistic, and culturally diverse manner while valuing diversity and self awareness.

Values
Equivalence, Diversity, Empowerment, Interdependency, and Knowledge.

Services Provided
The Workout Couch is a client centered practice geared towards helping clients during life cycle transitions while using a holistic approach. Cognitive Behavioral Therapy, Psychodynamic Therapy, and Mindfulness approaches are all used as interventions to help clients reach their highest potential. Collaborating both physical and mental health aides in self empowerment, strength, and mental agility to promote personal growth.

The Couch
For any individuals seeking help with depression, anxiety, life transition issues, postpartum depression, perinatal mood and overall mental health maintenance. Services are offered based on the clients needs on a weekly or biweekly schedule. Clients also opt to attend sessions monthly for maintenance. Clients can choose from individual and group therapy services.

Information for Clients

Your Rights As a client, you can expect Keisha Reaves, LPC to provide compassionate, confidential, appropriate, and competent help with your problems or concerns. You can also expect to be informed of the benefits and risks of treatment.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder. Physical activity and proximity has an impact on the connection between client and therapist. This should never be misunderstood as an attempt to take advantage of physical proximity with a client. Sexual relationships or innuendo are never appropriate and are unethical.

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. In your intake forms, you will receive a fee structure as well as information concerning techniques and methods of treatment.

Confidentiality & Records. The psychotherapy relationship is confidential. Information revealed within this relationship is between client and therapist. Keisha Reaves, LPC makes every effort to maintain your privacy and confidentiality. You (or the parent or legal guardian of a minor) must give your permission but signing a release of information before any information may be revealed to anyone else. However, there are some limitations to your right to confidential treatment:

Keisha Reaves, LPC regularly consults with other therapists to insure the best treatment possible. Consultations are bound by the same confidentiality as that between you and Keisha Reaves.

In marriage and family counseling, therapist holds to a "no secrets" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the therapist. There is no discriminatory treatment of family members.

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my locked office. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed.
I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

Adolescents

A child seventeen or younger seen in this office must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or legal guardians or the document presented giving sole custody.

Appropriate Treatment. Keisha Reaves, LPC will work with you to determine the most appropriate treatment for the difficulties you are experiencing. This includes developing a treatment plan, providing psychotherapy, consultations, or referring you to another professional with the appropriate expertise.

Competent Care. You have the right to competent, quality treatment that is consistent with professional standards established in practice and supported by research.

Informed Consent. You have the right to know the potential benefits and risks of psychotherapy in order to make an informed choice regarding your treatment. Keisha Reaves, LPC is committed to using her skill and knowledge to help resolve any difficulties that arise. However, psychotherapy is not an exact science. While therapy most often improves or alleviates problems, there is still the possibility that you may experience negative effects from therapy despite your best efforts and those of Keisha Reaves, LPC. Negative effects could include the worsening of problems, strained or damaged relationships with others during treatment, and the uncovering of unexpected, disturbing issues.

Cancellation Policy. Clients are seen by appointment only. Cancellations must be made at least 24-hours in advance of the scheduled time. A cancellation fee will be charged to clients who do not provide this notice.

Questions or Concerns. Keisha Reaves, LPC is committed to providing excellent service. If you have questions or concerns about the service she provides, she will be happy to address them with you.
If you have any questions or would like additional information, please feel free to ask during the initial session or anytime during the psychotherapy process.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Counselor Association. If at any time you feel that I am not performing in an ethical or professional manner, due to the very nature of psychotherapy, as much as I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

Statement of Fee Policy

Keisha Reaves, licensed profession counselor, provides psychotherapy, educational, and consultation services. I am requesting that you read and sign this statement to acknowledge your understanding of the policy.

Insurance Billing: You are asked to contact your insurance company relative to your benefits so that you are fully aware of your outpatient mental health benefits. Prior to your initial intake appointment, Keisha Reaves, will obtain your insurance information in order to find out what your in-network benefits are so that she can inform you of your coverage and co-payment. If you have an insurance that is not Blue Cross Blue Shield, Aetna or Magellan, you will have to follow-up with your insurance independently to see what your out-of-network benefits are and what process you need to take in order for you to file a claim for reimbursement.

Co-Pay: Payment is due prior to services being rendered. Clients will receive an online invoice more than 24-hours prior to their appointment to pay for their session. If this payment has not been paid within-in 24-hours prior to the appointment, the appointment will be considered as cancelled, unless otherwise discussed with your clinician.

Cancellations: The time of your scheduled appointment is reserved for you. It is our policy to charge $25 cancellation fee when the appointment is cancelled less than 24-hours of the scheduled time. We understand that circumstances arise that make it difficult to keep an appointment. We will work with you relative to these charges. A card MUST be kept on file. In the event you do not cancel your appointment within 24-hours of your appointment, your card will automatically be debited $25 to cover the cancellation fee.

This will also apply to clients using their employee assistance program to (EAP) to cover their session fees. Employee assistance does not cover no-show appointments.

Length of session: A session is generally between 45-60 minutes. There is no additional charge for other individuals such as spouse, children, relatives, or friends who may need to attend your session at your request.

Filing Out-of-Network Insurance Reimbursement. Insurance companies have many rules and requirements specific to certain plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I gladly provide you with a form called a "super-bill" which you can provide to your insurance for reimbursement.

In Case of an Emergency
My practice is considered to be outpatient office setting, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

-Call Behavioral Health Link/GCAL: 800-715-4225 or other crisis hotline
-Call Ridgeview Institute at 770.434.4567 or local hospital
-Call Peachford Hospital at 770.454.5589 or local hospital
-Call 911.
-Go to your nearest emergency room.

Cost Per Session if you are NOT using your insurance:

The Couch (individual
therapy)
60 minute session
weekly
$85.00 per session

Sliding Scale (individual therapy) *only a few slots are available at a time per year
50 Minute session
Weekly or biweekly
$50-$65 per session

Sliding Scale
If I am signing here, I am aware that I have been granted a sliding scale slot. Due to the limited number of slots available, I am agreeing that by holding this slot I am acknowledging that in the event I no-call/no-show to an appointment I forfeit my slot and will then have to move to paying full price per session. I also acknowledge that I am agreeing to attend a session at a minimum of once per month. And lastly, once my financial situation has changed and I can fully afford to pay the full-price, I will inform my clinician.

Signed:_____________________________________ Date:____________

Consent to Treatment & Fee Agreement

____ I participate in psychotherapy at this time and I understand that I may terminate my therapy at any time
initial without penalty.

____ I have read the "Information for Clients" form and I understand my rights and responsibilities Initial as a
initial client. I understand that I have a right to confidentiality in therapy and information about me.

____ I also understand the limitations of confidentiality regarding situations, in which I or another person could
initial be harmed, suspected neglect or abuse of a child or vulnerable adult, court order, professional consultation, and any other exceptions as noted in the form.

____ I have read and understand the information regarding fees and payments.
Initial

____ There is a $25 fee for sessions cancelled without a 24-hour notice, which will automatically be charged to
Initial in the event you miss an appointment without given proper notice according to the cancellation policy.

____ If you are a parent or guardian of a minor in therapy, you are responsible for the payment
Initial of services for the minor.

____ If your insurance is out-of-network and you want reimbursement, it is your responsibility to bill your own
Initial insurance company.

____ I am aware that my payment for my session must be paid 24-hours prior to my appointment in order to
Initial keep my appointment unless otherwise discussed with my clinician.

____ I understand that if I am choosing to use my insurance to cover my services that at any time my insurance
Initial company may request to audit my client files (progress notes, diagnosis, treatment plan goals, etc.) at any time in order to continue paying for my services.

_____ I understand that my co-payment is _______ for each session that I attend.
Initial

____

Client Signature Date

____

Client Name (print) Date

____

Custodial Parent or Guardian Signature Date

____

Psychotherapist Signature Date

Intake Form
Please provider the following information and answer the questions below. Please note that the information that you provide is protected as confidential information. Please fill out this form and bring with you on your first session.

Print Name:____
(Last) (First) (Middle)

____
(Parent or Guardian if client is under 18) (Last) (First)

Birth Date: __________ / __________ / ___________ Age: _______
Gender: Male/Female Marital Status: Single/Domestic Partner/Married/Separated/Divorced/Widows
Please list any children/age: Address:
Home Phone:____________________________________May we correspond by this method? Yes/No
Cell:____May we correspond by this method? Yes/No Work
Phone:____________________________________May we correspond by this method? Yes/No
Email:____May we correspond by this method? Yes/No
Okay to leave a discreet message/voicemail: yes or no
Referred By (if any):____

General Health and Mental Health Information
How many times per week do you generally exercise? __________________________________

What types of exercise do you participate in? ____

Please list any difficulties you experience with your appetite or eating patterns?
____
____
____
____
Are you currently employed? Yes/No
If yes, what type of work do you do? ____
Do you enjoy your work? Is there anything stressful about your current work?
____
____

Your Current Living Situation **(please circle which one fits your situation)**
Living with your husband

Living with your partner/ Significant Other

Living as a single parent with your children

Living on your own (alone or with roommate)

Living with your family of origin (parents, etc.)

Living in a group home

homeless

other (describe)_____________________

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay
__ Asexual __ In Question __Other
Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial __American Indian/
Alaska Native __ Middle Eastern/Middle Eastern-American __Asian/Asian-American/Asian Pacific Islander
__White/European-American __Not listed

FAMILY:
How would you describe your relationship with your mother?______________________________
____
How would you describe your relationship with your father?_______________________________
____
Are your parents still married?_____________ If they divorced, how old were you when they separated or divorced, and how did this impact you? ______________________________________
____
Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: ____________________________________
____
How many sisters do you have? ______ Ages? ____
How many brothers do you have? ______ Ages? ____
How would you describe your relationships with your siblings? ____________________________
____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:
Currently in Relationship? ____ How Long? ____
Relationship Satisfaction: 1 2 3 4 5 6 7 (from poor to excellent)
Married/Life Partnered? _____ How Long? ____
Previously Married/Life Partnered? YES NO
Gender _________

If so, length of previous marriages/committed partnerships__________________________
Do you have Children?____ If YES, how many and what are their ages:______________________
Describe any problems any of your children are having: ___________________________________
____
List the names and ages of those living in your household: _________________________________
____
Please briefly describe any history of abuse, neglect and/or trauma: _________________________
____
__ ____
POOR EXCELLENT Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:____________________________________
____

____

Is spirituality important in your life and if so please explain:____

____

Any current medical problems? ____

Your current psychiatrist's name/address/phone:

____

____

____

____

Any previous suicide attempts? list number of times, methods, dates

____

____

____

____

Previous Self-Injury? List number of times, methods, dates

____

____

____

____

Previous Homicide or Violence (including children)?

____

____

____

____

Previous Psychiatric Hospitalization? Where and When?

____

____

____

____

Drug and Alcohol History

Drug Name	Age of 1st Use	Current Amt/Freq	Peak Amt./Freq.	Last Use
Marijuana				
Cocaine				
Alcohol				
Sedatives				
Hallucinogens				
Amphetamines				
Inhalants				

Treatments for Drug or Alcohol Abuse: List locations, dates of treatment, duration. Inpatient detox____
Long-term Residential____
Outpatient____
List all medicines, vitamins, and herbs you are currently taking:
____

Name of Medication

Name of Medication	Dose	How Often	Reason for Medication

Please Check All that Apply & Circle the Main Problem:

Difficulties with:	Presently	In the Past	Difficulties With:	Presently	In the Past
Anxiety			Chills or Hot flashes		
Depression			People in General		
Mood Changes			Sexual Concerns		
Anger or Temper			Financial Concerns		

Difficulties with:	Presently	In the Past	Difficulties With:	Presently	In the Past
Panic			Legal Problems		
Fears			Domestic Violence		
Irritability			Thoughts of Hurting Someone		
Feeling Manic			Thoughts of Suicide		
Trusting Others			Sleeping too much		
Communicating w/ Others			Waking up too early		
Frequent Vomiting			Head injury		
Eating Problems			Nightmares		
Severe Weight Gain			Nausea		
Concentration			Fainting		
Headaches			Dizziness		
Loss of Memory			Diarrhea		
Excessive Working			Shortness of Breath		
Severe Weight Loss			Chest Pain		
Blackouts			Easily Distracted		
Speak without Thinking			Often Makes Careless Mistakes		
Completing Tasks			Hyperactivity		

FAMILY HISTORY OF (Check all that apply):

Drug.Alcohol Problems		**Physical Abuse**		**Depression**	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disability		“Nervous Breakdown”	

Any additional information you would like to include:
____

____
What's the main concern that you are having currently that has brought you in for a visit?
____

____

____

____