Beacon Family Therapy and Wellness Services
Therapy for Individuals, Couples, and Families
300 E. Arlington Blvd, Suite #9A Greenville, NC 27858
(252) 481-2961 rappleyead@gmail.com

Informed Consent

General Information:

Beacon Family Therapy & Wellness Services, PLLC provides marriage and family therapy services. Our goal is to provide consistent and professionally competent services for our clients. Do not hesitate to ask questions or discuss any part of the counseling process with your therapist. The most important aspect of the therapeutic process is the relationship between the therapist and the client. Therefore, we welcome, and encourage, any questions you may have. Additionally, please feel free to reference our website: www.beaconfamilytherapy.com

Confidentiality:

Case records will be kept confidential and private unless disclosure is authorized or required by law. Under current North Carolina law, what the clients says to the therapist is not protected completely as a "privileged communication." North Carolina law and ethical practice requires us to notify appropriate state agencies if your therapist suspects or knows of:

- Any incident involving child abuse or neglect
- Any incident involving abuse or neglect to an elderly person who is 70 years of age or older or to an at-risk adult with an intellectual or developmental disability,
- if there is an eminent danger to yourself and/or another person
- if your therapist is subpoenaed by a court of law

In matters where disclosure is not authorized or required by law, confidential information will not be released without your written authorization. In situations where a written consent is necessary and there are multiple clients who are a part of therapy (e.g., couple, family group, and other instances), all clients will need to sign a written consent for your therapist to release confidential information.

Consent:

By signing this form, you voluntarily consent to receive therapy services or have your child accept services provided by your therapist. Also, it is understood that you may leave therapy at any time, although terminating therapy is best accomplished in consultation with your therapist. This consent to services will be valid and remain in effect as long as you are receiving services, unless it is revoked by you, with written notice provided to the therapist aforementioned.

Responsibilities and Risks:

I (the client) understand that therapy has the potential for emotional stress, strains and life changes. I understand that my therapist is a resource, but that it is my responsibility to work hard to change thoughts, feelings and relationships. I understand that there are no guarantees of results from therapy.

Payment and Cancellations:

Payment is due following each 50-minute session. If additional time is requested, it will be billed in ½ hour increments. If you are using insurance to support therapy, it is your responsibility to obtain reimbursement by your insurance. The standard fee for therapeutic services from Damon Rappleyea, Ph.D., LMFT, is $135.00 per clinical hour (50 minutes). Please notify your therapist if you are unable to attend a session 24 hours in advance. If you do not provide your therapist with at least 24 hours' notice in advance, you are responsible for full payment for the missed session. Therapy may be terminated if you miss two consecutive sessions or get behind on payment for more than two sessions. Payments may be made by cash, check, or credit card. If you chose to pay by credit card there is a small processing fee that will be your responsibility (typically 3%). If you have any concerns regarding payment, please feel free to discuss them with your therapist. After discussing the fee agreements and breakdown, you agree to pay the following fees:

Client Pay: $_____ Other_____ Pay: $_____

Therapist Availability/ Emergencies:

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to the belief that important issues are better addressed within regularly scheduled sessions. Telephone conversations longer than ten minutes will be billed at ½ hour rates based on your clinical rate.

You may leave a message for your therapist at any time in their confidential voicemail. For Damon Rappleyea please call (252) 481-2961. If you would like for your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have a medical or psychiatric emergency, please call 911.

Therapy Versus Evaluation:

I understand that a therapeutic assessment is different from a forensic evaluation. A therapeutic assessment is conducted for the purpose of helping the person being assessed. A forensic evaluation is conducted solely to establish the facts of a situation so this information can be reported in court and used to make some type of determination. I understand that I am seeking therapy rather than a forensic evaluation. I also understand that should I need a forensic evaluation, for any purpose, my therapist can provide me with referrals to other providers for this service. Finally, I understand that my therapist cannot do both, provide therapy and provide an evaluation. Functioning in both roles would be inappropriate and it needs to be determined from the beginning which role is being provided.

Also, if you are involved in divorce or custody litigation, the role of your therapist is not to make recommendations to the court concerning custody or parenting issues. By signing the disclosure statement, you agree not to subpoena your therapist to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that your therapist write any reports to the court or your attorney making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interest of the family's children.

Electronic Communications:

Your therapist cannot ensure the confidentiality of any form of communication through electronic media, including text messages. You are also advised that any email sent to your therapist via computer in a work-place environment is legally accessible by an employer. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, your therapist will do so. However, you need to understand that this type of communication is not secure and jeopardizes your confidentiality. While your therapist may try to return messages in a timely manner, your therapist cannot guarantee an immediate response and requests that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

About the Therapy Process:

It is the intention of your therapist to provide professional services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Remember, therapy is a service that you purchase, and if you are not happy with the services received, it is your responsibility to make that known so we can discuss any hindrances to your progress. Your therapist will also periodically initiate discussions about the progress of treatment.

Due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or guarantee a specific outcome or result. I certify that this form, including the statements on the limits of confidentiality, has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents. I certify that I have legal authority to give consent for the treatment of all minor children that are included in therapy. I certify that I have received a copy of this form.

X_____
Client/ Other Legally authorized Person

X_____
***Client/Other Legally authorized Person**

X_____
Print Name and Relationship to Client

X_____
Print name and Relationship to Client

DATE:_____

TIME: _____

Client Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in planning the best services for you. Please answer each item carefully. If you do not understand any item, please ask your therapist for clarification.

Full Name:_____ Date:_____

Address:_____

Telephone number(s): Home (_____) _____ Leave Message: □Yes □No
Work: (_____) _____ Leave Message: □Yes □No

Age: _____ Sex: □Male □Female

Relational status: _____

Occupation: _____

Gross annual family income: _____

Highest level of education: _____

Religious preference: _____

Who do you live with?

Name	Age	Sex (m/f)	Relationship

Are you presently taking any medications? □Yes □No

If yes, please list medication name, dosage, and prescribing physician.

_____
_____

List any health problems for which you currently receive treatment.

_____
_____
_____
_____

Have you ever considered suicide? □Yes □No_____
Have you ever attempted suicide? □Yes □No If yes, when? _____

Briefly describe your reasons for seeking counseling

_____
_____
_____
_____

Have you ever consulted a counselor before? ☐ Yes ☐ No

Where When For how long For what reason

_____
_____

What was your reaction to your previous counseling?

_____
_____
_____

How many sessions do you think it will take to resolve the issues that brought you to counseling?

_____

How did you hear about my services?_____

If it was the internet, which site? ☐ www.beaconfamilytherapy.com
☐ Psychology Today directory

Circle any of the following that are presently causing you difficulty:

Assertiveness	Health problems	Career choices	Separation
Parenting	Alcohol use	Legal matters	Self-concept
Sexual problems	Marriage	Religion	Divorce
Nightmares	Loneliness	In-laws	Temper
Self-control	Communication	My past	Suicidal thoughts
Nervousness	Lack of Energy	Sleep	Decision making
Physical abuse	Children	Parents	Insomnia
Depression	Sexual abuse	Shyness	Guilt
Stress	Inferiority	Friends	Dating
Memory	Drug use	Headaches	Tiredness
Finances	Appetite	School	Unhappiness
Fears	Work	Confusion	Premarital

Other _____

Please **UNDERLINE** the items that are causing you the MOST difficulty.

Locke-Wallace Marital Adjustment Test (MAT)

Name: _____ Circle one: Male Female Date: _____

1. Check the dot on the scale line below which best describes the degree of happiness, everything considered, of your present marriage. The middle point, "happy," represents the degree of happiness which most people get from marriage, and the scale gradually ranges on one side to those few who are very unhappy in marriage, and on the other, to those few who experience extreme joy or felicity in marriage.

. . . . . .

Very Unhappy Happy Perfectly Happy

2. State the approximate extent of agreement or disagreement between you and your mate on the following items. Please check each column.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
a. Handling family finances						
b. Matters of recreation						
c. Demonstration of affection						
d. Friends						
e. Sex relations						
f. Conventionality (right, good, proper conduct)						
g. Philosophy of life						
h. Ways of dealing with in-laws						

10. When disagreements arise, they usually result in:
Husband giving in [] Wife giving in [] Agreement by mutual give and take []

11. Do you and your mate engage in outside interests together?
All of them [] Some of them [] Very few of them [] None of them []

12. In leisure time do you generally prefer: to be "on the go" [] stay at home []
Does your mate generally prefer: to be "on the go" [] stay at home []

13. Do you ever wish you had not married?
Frequently [] Occasionally [] Rarely [] Never []

14. If you have your life to live over, do you think you would:
Marry the same person [] Marry a different person [] Not marry at all []

15. Do you confide in your mate:
Almost never [] Rarely [] In most things [] In everything []

Locke—Wallace, 1959

Brief Accessibility, Responsiveness, and Engagement (BARE) Scale

Please circle the number that best represents your experiences in your current relationship with your partner.

1 = Never True; 2 = Rarely True; 3 = Sometimes True; 4 = Usually True; 5 = Always True.

Accessibility

1. I am rarely available to my partner. 1 2 3 4 5
2. It is hard for my partner to get my attention. 1 2 3 4 5

Responsiveness

3. I listen when my partner shares her/his deepest feelings. 1 2 3 4 5
4. I am confident I reach out to my partner 1 2 3 4 5

Engagement

5. It is hard for me to confide in my partner. 1 2 3 4 5
6. I struggle to feel close and engaged in our relationship. 1 2 3 4 5

Partner's Accessibility

7. My partner is rarely available to me. 1 2 3 4 5
8. It is hard for me to get my partner's attention. 1 2 3 4 5

Partner's Responsiveness

9. My partner listens when I share my deepest feelings. 1 2 3 4 5
10. I am confident my partner reaches out to me. 1 2 3 4 5

Partner's Engagement

11. It is hard for my partner to confide in me. 1 2 3 4 5
12. My partner struggles to feel close and engaged in our relationship. 1 2 3 4 5

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often …

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often …

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever…

Touch or fondle you or have you touch their body in a sexual way?

or

Try to or actually have oral, anal, or vaginal sex with you?

Yes No If yes enter 1 _____

4. Did you often feel that …

No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you often feel that …

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?

Yes No If yes enter 1 _____

7. Was your mother or stepmother:

Often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score