Jesse L. Williams, MS, LPC/MHSP, NCC, CCH
Trauma and Anxiety Center, LLC
200 East Broadway Avenue Suite 150
Maryville, TN 37804
jesse@traumaanxietycenter.com
www.traumaanxietycenter.com
(865) 518-9922

INFORMED CONSENT OF PSYCHOTHERAPY AND SERVICES

Welcome to my therapy practice. Beginning therapy is an important decision, and I am glad I can be a part of that experience for you. If, after the first meeting, we decide to enter into a therapeutic relationship, it is important that you be aware of the protections and limitations of that relationship. Subsequently, **please make sure you read this informed consent in its entirety to ensure that you have a thorough understanding of therapy.** We will have the chance to review the following information together and any questions regarding the information will be addressed. If you are not comfortable with both your rights as a client and my limitations as your therapeutic partner, we can discuss other options for treatment.

What is Psychotherapy?

Psychotherapy is a way to understand human behavior and to help people with a variety of problems. Psychotherapy typically starts with an assessment of problematic symptoms and maladaptive behaviors that are affecting a person's life. Strategies may be employed to alleviate symptoms of depression, anxiety, or relationship problems; however, I believe that such coping skills are ultimately short-lived without insight and exploration of the cause of such issues. *Self-knowledge and insight is seen as an important key to changing attitudes and behaviors*.

Whether or not therapy works depends a great deal on the client's willingness and ability to fully engage in the therapeutic relationship. Each client has a unique opportunity to view themselves more accurately and to make connections between the past and the present. Therapy may be emotionally painful at times. Clients are encouraged to talk about thoughts and feelings that arise in therapy, especially feelings towards the therapist. These feelings are important because elements of one's history (past relationships, conflicts, etc) can be shifted onto the therapist and the process of therapy. Psychotherapy aims to help people experience life more deeply, enjoy

Initial Here:_____

more satisfying relationships, resolve painful conflicts, holistically balance self, and better integrate all the parts of their personalities.

I emphasize an insight-driven form of psychotherapy that involves looking holistically at the individual. The goal with this form of therapy is to help the individual view themselves as a holistic, empowered being and to begin making adjustments to affect change. Therapy is designed to help clients understand how one unbalanced aspect of life health can ultimately results in problems throughout multiple systems (relationships, health, emotions, behaviors, thoughts, etc). Each client will be encouraged to dig deep for answers and insights as to why a problem is occurring and how to ultimately resolve, eliminate, and/or manage the issue.

Much of my therapy approach would be considered an experiential, eclectic style of psychotherapy. "Experiential" because an emphasis is placed on the experience itself, which shifts the focus towards more of a mind/body connection. "Eclectic" because I piece together various approaches, such as traditional talk therapy, hypnotherapy, life-coaching, trauma-resolution therapy, cognitive/behavioral therapy, energy healing approaches, nature/hike therapy, and tarot-based therapy. Part of my job is to stay aware of what you believe you need to focus on and to educate you on various methods/techniques we could use in order to achieve your goals. At certain times during our work together, we may feel that another approach or technique may be needed in addition to traditional psychotherapy/talk-therapy. I will always discuss the options with you as my client, and I allow you to pick and choose what you believe would work best for your healing.

Benefits and Risks of Treatment

There are many benefits to psychotherapy. These benefits have been established by scientific research but are sometimes difficult to monitor or pinpoint. I am responsible for ensuring that, for the most part, the benefits of your therapy outweigh the risks. I will always do my best to keep you informed of any possible risks as we make treatment decisions together. I will also assist you in getting to another treatment resource if at any time you decide that you would like to make a treatment change. My belief is that any person who has a desire to heal and/or change can do so with proper help and support. Ultimately, the decision to make changes is yours. I am here only to guide and assist you on your journey.

Unfortunately, there are no guarantees that any or all of your problems will be remedied by pursuing treatment with me. It is quite possible that you may experience stress, strained relationships, increased symptoms, and other difficulties as a result of working in therapy, especially as you share painful feelings and thoughts that can cause unpleasant internal experiences. Growth is difficult, and often things feel worse before they feel better. You may experience stress or difficulty as you are challenged to make major life decisions and/or changes. It is helpful to talk about these issues as they surface.

Initial Here:_____

Please know that change is slow, and often patience is required by both the client and therapist as this process continues.

Boundaries of the Therapeutic Relationship

The therapeutic relationship is a unique relationship unlike other relationships. For your protection and to preserve the integrity of our work, there are certain boundaries which are held in therapy. You are expected to come to therapy, live up to your financial obligations, and be honest in our work together. I am expected to provide services to the best of my ability, to maintain ethical and legal expectations, and to honor and uphold your healing process.

Although therapy work can be extremely personal and meaningful, the relationship will always remain professional. We will only meet in my office or designated location at scheduled times. Please be aware that because we live in a small community, our paths may cross in unexpected ways outside of a session. In these instances, I will always follow your lead on how to handle the situation, and we can discuss the occurrence afterwards.

Should you have any questions about boundaries at any part of our therapeutic relationship, do not hesitate to ask and bring this up for exploration and discussion. We can discuss any particular feelings you may have in response to these therapeutic boundaries. In fact, this is an important part of the therapy process if and when it becomes an issue.

Credentials and Background

I graduated from Southeastern Louisiana University in 2008 with a Bachelor of Science and from Walden University in 2016 with a Master of Science in Clinical Mental Health Counseling. I completed my counseling internship at Skyland Trail, a residential treatment facility in Atlanta, GA, where I worked with clients with thought disorders and psychosis, as well as a variety of other mental health issues. In the past several years, I have dedicated much of my time and training opportunities towards the treatment of anxiety, trauma, and identity work. My ongoing trainings have included such topics as suicide prevention, anxiety management, hypnotherapy, acceptance and integration training (AAIT), somatic experiencing, reiki/energy healing, ethics, life coaching, shamanic/nature-based healing, and various trauma healing practices. I am a Licensed Professional Counselor with Mental Health Service Provider designation (LPC/MHSP) (License #4417), a National Certified Counselor (NCC), and a Certified Clinical Hypnotherapist (CCH). Additionally, I have experience with nature-based therapy/therapeutic hikes, and I am certified and trained in levels I and II of HMR (holographic memory resolution), a trauma resolution technique. I am a certified Reiki healer (Levels I and II) and have over ten years of experience in the therapeutic use of tarot cards for the purposes of subconscious associations, insight, and self-exploration.

Initial Here:_____

OFFICE POLICIES

Scheduling and Cancellations

All scheduling is done by me; therefore, any cancellations or appointment changes must go through me. The best way to reach me regarding scheduling is through text to (865) 518-9922 or email to jesse@traumaanxietycenter.com. You may also leave a voice message if you would prefer that method.

Also, because wireless communication is not 100% reliable, **my policy is that no appointment should be considered cancelled unless it is confirmed by a response from me.** I would also appreciate a confirmation that you have heard from me about appointment changes.

Cancellations must be made at least 24 hours in advance in order to avoid being charged 50% of the session rate that we have agreed upon. I do not waive this fee except in the case of an emergency (such as hospitalization, family death, car accident, etc.). Simply not showing for an appointment ("No-show") requires full payment of the missed appointment at the rate that we have agreed upon. These charges must be paid in full prior to rescheduling. If you consistently late cancel appointments, you may be terminated from the therapy relationship due to noncompliance. Not showing for an appointment is generally not tolerated and may result in termination from the therapy relationship. Additionally, consistent cancellations may also result in termination of the therapy relationship.

Frequent cancellations, late cancellations, and no-shows can result in possible termination from therapy due to non-compliance. Additionally, late-cancellations and no-shows result in a charge for the appointment time.

Please recognize that when you make an appointment, I am promising that space and time for you and your healing process. It is reserved specifically for you. If you are late, I will not be able extend your appointment time as I have a structured schedule that is planned by the hour. I schedule blocks of time. If someone doesn't show up, I cannot see another client, and clients that are trying to get an appointment cannot come in. That time is lost.

I know this can be an emotional and controversial subject, and yet, it is a necessary point of discussion. Frequent cancellations, late cancellations, and no-shows are oftentimes a sign of a noncommittal attitude towards the therapy process and/or core issues surfacing for you, so I encourage you to address these with me and use the opportunity to explore hesitations, doubts, or challenges.

Payment Policies

You will be financially responsible for all services rendered. **Payment is required at the time of the session in the office.** I am not on insurance panels and do not accept insurance. Payment can

Initial Here:_____

be made in cash or with most major credit cards (Visa, Mastercard, American Express, Discover) using a Square reader (Square.com). Check are not an accepted form of payment.

Please note that credit card payments will require a 3% courtesy fee (4% for transactions that occur without the use of the card present, such as invoices and the use of card numbers).

Any billing or payment issues should be discussed with me immediately so that we can resolve any problems and address any concerns. If you are delinquent with payment, payment will be required prior to rescheduling.

Rates

My standard rates are listed below:

Psychotherapy/Reiki/Hypnotherapy/Other	***$150 for 50-minute session***
Extended Session	***$225 for 80-minute session***

Although these are my standard rates, I work on a sliding fee scale, which means I am able to offer a certain number of sessions per week at an adjusted rate for clients who are unable to pay the full amount. Assuming that I have available slots on my schedule, I can reduce the rate of services by up to 33%. If you are interested in an adjusted rate for any services, we can discuss this together and assess your need for an adjusted rate. I ask that these slots be reserved for people who truly need the financial assistance; however, if you need it—ask!

The Appointment Hour

A therapy "hour" consists of 50-minutes of therapy time. If more time is needed, arrangements can be made for longer therapy sessions; the fee will be adjusted accordingly. If I am late for an appointment, I will either complete with you the full time of your appointment (assuming your schedule permits), owe you the extra time, or adjust your rate for that session. If you are late, the appointment will end at its scheduled time and you are responsible for full payment.

Communication

Secure and private communication cannot be fully assured utilizing cell/smart phone, texting, or regular email technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact Jesse Williams, LPC/MHSP, will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. In the event that client chooses not to allow non-secure modes of communication, contact will only be made via wire to wire phone or mail.

Initial Here:_____

Please note that receipts of service are typically sent by text or email through the Square App.

Unless my voicemail states otherwise, I check messages regularly both weekdays and weekends. On weekends and holidays, however, I reserve the right to only return calls, texts, or emails of an urgent nature. If I you call my phone and I do not answer, please leave a voicemail in order for me to know that you have called. Because cell service in our area can be unreliable, voicemails often let me know if someone has tried calling.

Please check below which modes of communication are permitted. This consent may be altered at any time if needed.

Voice communication to client's cell/smart phone from Jesse Williams' cell/smart phone:

Scheduling appointments: □ Permitted □ Not Permitted

Appointment reminders: □ Permitted □ Not Permitted

Between session contact: □ Permitted □ Not Permitted

Text communication to client's cell/smart phone from Jesse Williams' cell/smart phone for:

Scheduling appointments: □ Permitted □ Not Permitted

Appointment reminders: □ Permitted □ Not Permitted

Between session contact: □ Permitted □ Not Permitted

Contact via the client's email from Jesse Williams' email:

Scheduling appointments: □ Permitted □ Not Permitted

Appointment reminders: □ Permitted □ Not Permitted

Between session contact: □ Permitted □ Not Permitted

If permitted, list permitted email address: _____

If permitted, list permitted cell number: _____

Emergency Needs

I try to make myself available for emergencies. If for some reason, you call and do not get a response, and are experiencing a genuine emergency, you are advised to call 911 or go to your

nearest mental health facility or emergency room. The Helen Ross McNabb Center offers a mobile crisis hotline at (865) 539-2409. Additionally, Peninsula Hospital has a 24-hour emergency walk-in assessment center. They can be reached at (865) 970-9800. If you require hospitalization, I will stay in touch with your treating mental health professionals with your permission. We can resume outpatient treatment after an assessment of your status and needs. There is no charge for a brief (10-minute) phone check-in if there is an emergent need. However, you will be charged accordingly for a longer session or phone consultation.

Confidentiality

As a client, your privacy and rights to confidentiality are protected. Confidential information may be disclosed when you, the client, give written valid consent or when a legally authorized person gives consent on your behalf. Information you share with me may be entered into records in written form. All written documentation regarding your treatment will be secured in a private physical location or a HIPPA compliant cloud destination. Information about you and your treatment will not be shared casually or in public places.

There are some limits to your rights to confidentiality. Information about your treatment may be shared during supervision/consultation with other professionals and/or members of your treatment team. When this occurs, this information will be limited to only that which is necessary and relevant. When possible, your identity will be protected.

State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.

2. A situation in which serious threat to a reasonable well-identified victim is communicated to the therapist.

3. When threat to injure or kill oneself is communicated to the therapist.

4. If you are required to sign a release of confidential information by your medical insurance provider.

5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. Think carefully and consult with an attorney before you sign away your rights.

Confidentiality for Couples/Families/Minors

Clients being seen in couple, family, or group work are obligated legally to respect the confidentiality of others. I will exercise discretion (but cannot promise absolute confidentiality)

Initial Here:_____

when disclosing private information to other participants in your treatment process. When I am working with couples, or a family with two legal guardians, I am obligated to preserve confidentiality on behalf of the couple. This means that I will not release any information about either member of the couple without the consent of both, including for divorce proceedings. This also means that I will not hold individual confidences of either party that will jeopardize my allegiance to both parties in the couple. Secrets cannot be kept by me from others involved in the therapy process—any secret that you tell me but refuse to share with your partner will result in termination of our therapeutic relationship.

When working with minors, I do not reveal to parents/guardians what was discussed in session, because this would interfere with the need to establish trust and rapport with your child. If a minor, however, tells me anything that makes me seriously concerned about his/her safety and well-being or the safety and well-being of someone else, the minor's only choice regarding confidentiality is to participate or not to participate in telling his/her parents/guardians.

Sessions Outside of the Office

During nature-based therapy or in certain circumstances where you and I decide that it would be beneficial for your treatment, the counseling session can/may occur outside of the office. In these situations, time, location, and intent will always be set up and agreed upon by both parties.

When outside of the office on such a locations as hiking trails or parks, you assume all responsibility for maintaining your own safety, and you must sign the required release form. Because nature-based therapy sessions are in nature, injuries and mishaps can occur that are outside of my responsibility, control, and foresight. Although I will do my best to prevent such situations or circumstances, I can not be held accountable or responsible for the following (but not limited to): insect bites/strings, snake bites, sprains, poison ivy, or any other injury which occurs as a result of being on a hiking trail or in a park. You, the client, assumes all risks associated with a this style of session.

Please note that confidentiality becomes less guaranteed when in public with your therapist. If this is a concern, please notify me so that we can make a plan prior to the session on how confidentiality will be dealt in an effort to keep your confidentiality intact. This is to protect you should either of us run into someone that we know.

Again, I will make every effort to protect your confidentiality; however, when outside of the office, circumstances that are outside of my control can occur. When agreeing to a session outside of the office, you assume all risks to your confidentiality that could occur as a result of being in a public location with your therapist. Before agreeing to this decision, be sure to think through these issues and ask me any questions that you might have so that we can address it prior to being in a public location.

In the case that we are meeting for nature-based therapy, be aware that cell service is at times

limited within certain areas, so you will need to plan accordingly. I encourage you tell a friend/ loved one where you are going, what time the session is, how long you expect to be gone, and who the session is with. Feel free to share my contact information with your emergency contact if you feel comfortable doing so.

Privacy

In daily practice, I may use email, written correspondence, and cellular phone service. In all these instances, confidentiality will be protected to the best of my ability, but is limited due to the risk of information being overheard or ending up in the wrong hands. Every precaution will be taken to protect your privacy.

Termination and Follow-up

Termination is an important process in psychotherapy. If you are ready to begin the process of terminating, we will discuss this at length and spend several sessions putting closure on our work together. Terminating treatment is usually up to the client. There are occasions, however, when I may initiate termination. The reasons for this decision will be discussed with you and will include an explanation. Possible reasons for a therapist terminating treatment include: failure on your part to comply with mutually developed treatment goals and procedures; the realization that you are not benefitting from therapy; consistent cancellations/late cancellations/no-shows; failure on your part to pay; any violent, abusive, threatening or litigious behavior on your part; and/or if the therapeutic relationship is compromised in any way due to unforeseen circumstances. Any non-voluntary termination will be accompanied by an appropriate referral.

I leave it up to you to call and request an appointment time. If you have a standing appointment and do not show, I will notify you. If I do not receive a response, I will take you off the schedule for any future appointments and will consider the therapy relationship to be terminated.

Client Rights

You have the right to information regarding my training and professional credentials.

You have the right to be treated by me in a consistently competent, ethical and respectful manner.

You have a right to a personal, individual assessment of your treatment needs in which your expertise about yourself is as important as my professional opinion about you.

You have a right to referrals to other competent professionals and services when your treatment needs indicate it.

You have a right to ask questions about the approach and methods I use and to decline the use of certain therapeutic techniques.

Initial Here:_____

You have the right to confidential treatment except in circumstances already described in this document.

You have the right to information regarding anticipated length of treatment and prognosis if you stop treatment.

You have the right to stop receiving therapy from me without any obligation other than to pay for the services you have already received unless you are a danger to yourself or someone else.

You have a right to resume services following termination after assessment.

You have a right to discuss your treatment, concerns, questions, and complaints with me.

Children in the Office

I highly discourage bringing of your child into your individual therapy sessions. Parenting requires a large amount of attention, energy, and strength, and this can often keep you feeling preoccupied, closed-off, or unable to address certain topics within a session. This can often serve as a block to the healing process, and it can be a great disservice to yourself. Additionally, children under 16 cannot be left without a parent or guardian in the waiting area at any time.

Interaction with the Legal System

You understand that you will not involve or engage me, as your therapist, in any legal issues or litigation in which you are a party to at any time either during your counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, disability evaluations/paperwork, or any other contact with the legal system. In the event that you wish to have a copy of your file, and you execute a proper release, I will provide you with a copy of your record. If you believe it necessary to subpoena me, as your therapist, you would be responsible for my expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day would be billed at the rate of $375.00 per hour including my travel time and expenses. You understand that if you subpoena your therapist, I may elect not to speak with your attorney, and a subpoena may result in me withdrawing as your therapist.

Initial Here:_____

PLEASE SIGN BELOW AND INITIAL THE RIGHT CORNER OF EACH PAGE TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION DESCRIBED HEREIN AND THAT YOU HAVE DISCUSSED WITH ME ANY PART OF THE INFORMATION YOU DO NOT UNDERSTAND.

ALL FAMILY MEMBERS PARTICIPATING SHOULD SIGN BELOW. IF MINOR CHILDREN ARE INVOLVED, PLEASE PRINT THEIR NAMES AND IDENTIFY WHO IS THE PARENT/GUARDIAN SIGNING FOR THEM.

THE ORIGINAL COPY OF THIS DOCUMENT WILL REMAIN IN MY FILE AND I WILL GIVE YOU A COPY FOR YOUR PERSONAL FILES IF NEEDED.

"I UNDERSTAND THE FINANCIAL POLICY, INCLUDING THE 24-HOUR CANCELLATION REQUIREMENT TO AVOID CHARGES FOR CANCELLED OR NO-SHOWED APPOINTMENTS. I ALSO UNDERSTAND THAT THIS PROVIDER IS NOT ON INSURANCE PANELS AND DOES NOT FILE INSURANCE CLAIMS."

AGREED UPON RATE: _____

Signature and printed name of client(s): **Date: _____**

_____

_____

_____

_____

Signature and printed name of parent/legal guardian(s) (if necessary):

_____

_____

Signature of Therapist: _____

Initial Here:_____

Jesse L. Williams, MS, LPC/MHSP, NCC, CCH
Trauma and Anxiety Center, LLC
200 East Broadway Avenue Suite 150
Maryville, TN 37804
jesse@traumaanxietycenter.com
www.traumaanxietycenter.com
(865) 518-9922

CLIENT INTAKE QUESTIONNAIRE

Please fill in the information below. If this paperwork is for a minor, please complete the questions from their perspective to the best of your ability, skipping any non-applicable questions.

Name:_____
(First) (Middle Initial) (Last)

Preferred Nickname:_____

Date:_____ Birth Date:_____ Age:_____

Gender: □ Male □ Female □ Other:_____

Preferred Pronouns: □ He/Him/His □ She/Her/Hers □ Other:_____

Sexuality: □ Heterosexual □ Bisexual □ Gay/Lesbian □ Other:_____

Marital Status: □ Single □ Married □ Domestic Partnership □ Separated □ Divorced □ Widowed

Please list any children/age:_____

_____

_____

Initial Here:_____

Current living situation: □ Live alone □ Live with others:_____

Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____)_____ May I leave a message? □Yes □No

Cell/Other Phone: (_____)_____ May I leave a message? □Yes □No

E-mail:_____ May I email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner:_____

Are you currently taking any prescription medication? □ Yes □ No

If "Yes," please list:_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If "Yes," please list and provide dates:_____

_____

_____

EMERGENCY CONTACT INFORMATION

Name:_____

Relationship to Client: _____

Phone Number: _____

Initial Here:_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse: □ No □ Yes: _____

Anxiety: □ No □ Yes: _____

Bipolar: □ No □ Yes: _____

Depression: □ No □ Yes: _____

Domestic Violence/Abusive Behaviors: □ No □ Yes: _____

Eating Disorders: □ No □ Yes: _____

Obsessive Compulsive Behaviors: □ No □ Yes: _____

Schizophrenia: □ No □ Yes: _____

Suicide Attempts: □ No □ Yes: _____

Any Other Noteworthy Details on Family of Origin:

_____

_____

_____

_____

_____

_____

_____

_____

Initial Here:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

6. Are you currently having anxiety, panic attacks, obsessive thoughts, or phobias? □ No □ Yes

If yes, when did you begin experiencing this?_____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational substances? □ Daily □ Weekly □ Infrequently
□ Monthly □ Never □ Prefer not to say

Initial Here:_____

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long?_____

On a scale of 1-10, how would you rate your relationship?_____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

12. Have you ever experienced any paranoia or auditory/visual hallucinations? □ No □ Yes

If yes, describe: _____

13. Have you ever had any past suicide attempts? □ No □ Yes

If yes, describe: _____

14. Have you ever been hospitalized for a reason associated with mental health? □ No □ Yes

If yes, describe: _____

15. Do you have a history of abuse, neglect, or trauma? □ No □ Yes

16. Do you currently have any hobbies that you enjoy? □ No □ Yes

If yes, please describe: _____

17. Do you have friends/family members whom you feel are supportive? □ No □ Yes

18. Do you have any past legal issues? □ No □ Yes

If yes, please describe: _____

19. Are your parents still living? □ Both living □ Mother only □ Father only □ Both deceased

Initial Here:_____

20. Do you have any siblings? □ No □ Yes

If yes, please tell ages, genders, and birth order:

_____

_____

_____

21. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation: _____

Do you enjoy your work? Is there anything stressful about your current work?_____

_____

22. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, please describe your faith, belief or spirituality:_____

_____

23. What brings you to therapy today?_____

_____

_____

24. What are your goals for therapy?_____

_____

_____

_____

25. Please give any additional information that you feel is important to know about you:

_____

_____

Initial Here:_____

PLEASE SIGN BELOW AND INITIAL THE RIGHT CORNER OF EACH PAGE TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTOOD THE QUESTIONS AND HAVE PROVIDED ACCURATE INFORMATION TO THE BEST OF YOUR KNOWLEDGE.

ALL FAMILY MEMBERS PARTICIPATING SHOULD SIGN BELOW. IF MINOR CHILDREN ARE INVOLVED, PLEASE PRINT THEIR NAMES AND IDENTIFY WHO IS THE PARENT/GUARDIAN SIGNING FOR THEM.

THE ORIGINAL COPY OF THIS DOCUMENT WILL REMAIN IN MY FILE AND I WILL GIVE YOU A COPY FOR YOUR PERSONAL FILES IF NEEDED.

Signature and printed name of client(s): **Date: _____**

_____

_____

_____

_____

Signature and printed name of parent/legal guardian(s) (if necessary):

_____

_____

Initial Here:_____

Jesse L. Williams, MS, LPC/MHSP, NCC, CCH
Trauma and Anxiety Center, LLC
200 East Broadway Avenue Suite 150
Maryville, TN 37804
jesse@traumaanxietycenter.com
www.traumaanxietycenter.com
(865) 518-9922

RELEASE AND LIABILITY WAIVER

Nature-based therapy sessions are meant to support clients in experiencing a deep and nurturing connections with the natural world, as well as in-depth experience and insight into their own internal worlds. These sessions generally involve a mild level of physical activity and great care is taken to support a client's well-being. Nevertheless, participation in any physical exercise or outdoor activity involves inherent risks that cannot be eliminated, regardless of the care taken to avoid injuries.

Assumptions of Inherent Risks

Client understands and acknowledges that nature-based therapy involves certain known and unknown risks which could result in injury, death, disability, physical or mental disease or illness, and damage to self, to property, or to bystanders or other third parties, including but not limited to the following:

a. insect bites, exposure to venomous snakes, contact dermatitis from poison ivy or similar plants, sunburn, dehydration, trips and falls resulting in injury, poorly maintained trails or building facilities, falling tree limbs, lightning strikes, hypothermia, hyperthermia, and attack by animals;

b. Client's own physical, medical, or psychological limitations that may lead to injury;

Initial Here:_____

c. that any of the above may occur in remote places without medical facilities or access to emergency treatment or other services required; and

d. additional unknown risks include but are not limited to those caused by the actions of other people including but not limited to participants.

CLIENT AGREES TO ASSUME AND SINGULARLY BEAR ALL RESPONSIBILITY AND RISK TO HIM OR HERSELF WHILE PARTICIPATING OR ENGAGING IN NATURE-BASED THERAPY.

Indemnification, Waiver, and Release

Client agrees to defend, indemnify and hold the Released Parties harmless from any claim by a third party resulting from damage or injury caused by client. Client and his/her heirs, distributes, guardians, legal representatives, and assigns HEREBY WAIVE ANY AND ALL RIGHTS AND CLAIMS FOR BODILY INJURY OR PROPERTY DAMAGE WHICH MAY OCCUR DURING THE NATURE-BASED THERAPY SESSION.

Client certifies that (s)he has sufficient health insurance, and auto insurance if (s)he intends to drive or ride with others during the session to cover any bodily injury or property damage (s)he may incur as a result of and during the duration of the session, and to cover bodily injury or property damages to a passenger or third party as a result of client's participation in the session and during the duration thereof.

Client and his/her heirs, distributes, guardians, legal representatives and assigns HEREBY RELEASE AND FOREVER DISCHARGE THE RELEASED PARTIES, AND EACH OF THEM, FROM ALL CLAIMS, ACTIONS, DEMANDS, RIGHTS, CAUSES OF ACTION AND LIABILITIES, EITHER IN LAW OR IN EQUITY, based on any bodily injury or property damage to client or any third party as a consequence of client's participation in the session or as a result of ordinary negligence on behalf of Trauma and Anxiety Center, LLC.

Client hereby agrees that (s)he shall never bring any lawsuit or other legal action against Trauma and Anxiety Center, LLC, or any of the Released Parties as a result of or in connection with client's participation in the session and agrees to release Released Parties from and against any and all known and unknown claims, liabilities, damages and costs. Client hereby expressly waives any rights he or she may have.

Initial Here:_____

Emergency Information

Client's Name:_____ Phone:_____

Emergency Contact Name:_____

Relationship to Client:_____ Phone:_____

Please list any allergies (insect bites/stings, medications, etc) PLUS any pertinent medical information:

_____

_____

_____

_____

_____

_____

General Provisions

Client expressly agrees that this Agreement is governed by the State of Tennessee and is intended to be as broad and inclusive as permitted by Tennessee law, and that in the event any portion of this Agreement is determined to be invalid, illegal, or unenforceable, the validity, legality and enforceability of the balance of the Agreement shall not be affected or impaired in any way and shall continue in full legal force and effect.

Client acknowledges that if a lawsuit is filed against Trauma and Anxiety Center, LLC, or any part of Trauma and Anxiety Center, LLC, for any injury or damage in breach of this contract, (s)he will pay all attorney's fees and costs incurred by Trauma and Anxiety Center, LLC, or their agents or employees in defending such an action.

Client acknowledge that circumstances could result in medical emergencies, and client gives his/her permission for Jesse Williams to seek emergency medical diagnosis/treatment for the client in the event that the client is unconscious or unable to make an informed decision. Therapist's role in medical treatment will be limited to supporting the client in application of his/her own first aid, transportation to a medical treatment facility, and/or contacting such facility to arrange emergency medical services and transportation.

Initial Here:_____

PLEASE SIGN BELOW AND INITIAL THE RIGHT CORNER OF EACH PAGE TO ACKNOWLEDGE THAT YOU HAVE DISCUSSED WITH ME ANY PART OF THE INFORMATION YOU DO NOT UNDERSTAND. CLIENT'S SIGNATURE BELOW INDICATES THAT (S)HE HAS READ THIS ENTIRE DOCUMENT, UNDERSTANDS IT COMPLETELY, UNDERSTANDS THAT IT AFFECTS HIS OR HER LEGAL RIGHTS, AND AGREES TO BE BOUND BY ITS TERMS. CLIENT UNDERSTANDS IT IS A PROMISE NOT TO SUE AND IS A WAIVER, RELEASE, AND INDEMNITY FOR ALL CLAIMS.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date set forth below.

ALL FAMILY MEMBERS PARTICIPATING SHOULD SIGN BELOW. IF MINOR CHILDREN ARE INVOLVED, PLEASE PRINT THEIR NAMES AND IDENTIFY WHO IS THE PARENT/GUARDIAN SIGNING FOR THEM.

THE ORIGINAL COPY OF THIS DOCUMENT WILL REMAIN IN MY FILE AND I WILL GIVE YOU A COPY FOR YOUR PERSONAL FILES IF NEEDED.

Signature and printed name of client(s): **Date: _____**

_____

_____

_____

_____

Signature and printed name of parent/legal guardian(s) (if necessary):

_____

_____

Signature of Therapist: _____

Initial Here:_____

Jesse L. Williams, MS, LPC/MHSP, NCC, CCH
Trauma and Anxiety Center, LLC
200 East Broadway Avenue Suite 150
Maryville, TN 37804
jesse@traumaanxietycenter.com
www.traumaanxietycenter.com
(865) 518-9922

VIDEO/PHONE-BASED THERAPY INFORMED CONSENT FORM

1. I understand that I am engaging in video/phone-based therapy with my provider.

2. I understand that the video/phone-based therapy will not be the same as in-person session with a provider due to the fact that I will not be in the same room as my provider. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session. I understand that my location for session should be in the state of Tennessee, per regulations surrounding limits of my provider's license to practice.

3. I understand the potential risks to this technology include: interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the video/phone-based therapy session if it is felt that the connections are not adequate for the situation. I agree to provide a working phone number to my provider prior to each session in case of technical difficulties. If technological issues with video sessions are unable to be troubleshooted, the session will occur over the phone.

4. I understand that doxy.me will be the platform over which video-therapy will occur, as it is HIPAA compliant. At the appointment time, I will log on to **https://sessions.psychologytoday.com/jesse-williams** and await for my provider to begin session.

5. I understand that in the case of technical difficulties or inconvenience with **https://sessions.psychologytoday.com/jesse-williams**, I can choose to utilize another video conferencing software that is HIPAA compliant, such as **https://doxy.me/jessew**. I also

Initial Here:_____

understand that I can also opt to use non-HIPAA compliant options, such as Skype or FaceTime. I understand that Skype and FaceTime are not HIPAA compliant options if I choose to use them and that my therapist can discuss with me the pros and cons of using an alternative software.

6. I understand that there are alternatives to a video/phone-based therapy session available, including the option of finding another provider to see in-person.

7. I understand that I can direct questions about this video/phone-based therapy session at any time to my provider, at Trauma and Anxiety Center, LLC.

8. I understand that this consent will last for the duration of the relationship with my provider, including any additional video/phone-based therapy sessions I may have; I can withdraw my consent for a video/phone-based therapy sessions at any time.

9. I understand that same confidentiality protections, limits to confidentiality, and rules around my records apply to a video therapy session as they would to an in-person session (see Informed Consent Form).

10. I understand that to ensure compliance with HIPAA, documents and communication with Trauma and Anxiety Center, LLC will be shared via provider's email, **jesse@traumaanxietycenter.com**. This account utilizes encryption to secure privacy of information.

11. I agree to work with my provider to come up with a safety plan in the event of a crisis situation during our sessions.

12. I understand that my provider may decide to terminate video/phone-based therapy services, if they deem it inappropriate for me to continue therapy through video/phone-based sessions.

13. My provider, **Jesse L. Williams, MS, LPC/MHSP**, agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I agree to inform my provider if there is another person present during the session or if I wish to tape the session.

Initial Here:_____

PLEASE SIGN BELOW AND INITIAL THE RIGHT CORNER OF EACH PAGE TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION DESCRIBED HEREIN AND THAT YOU HAVE DISCUSSED WITH ME ANY PART OF THE INFORMATION YOU DO NOT UNDERSTAND.

BY SIGNING THIS FORM, I CERTIFY THAT:

I HAVE READ OR HAD THIS FORM READ AND/OR HAD THIS CORM EXPLAINED TO ME.
I FULLY UNDERSTAND ITS CONTENTS INCLUDING THE RISKS AND BENEFITS OF THE PROCEDURE(S).
I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.
I AGREE TO PARTICIPATION IN A VIDEO/PHONE-BASED THERAPY SESSION(S) WITH TRAUMA AND ANXIETY CENTER, LLC.

ALL FAMILY MEMBERS PARTICIPATING SHOULD SIGN BELOW. IF MINOR CHILDREN ARE INVOLVED, PLEASE PRINT THEIR NAMES AND IDENTIFY WHO IS THE PARENT/GUARDIAN SIGNING FOR THEM.

THE ORIGINAL COPY OF THIS DOCUMENT WILL REMAIN IN MY FILE AND I WILL GIVE YOU A COPY FOR YOUR PERSONAL FILES IF NEEDED.

Signature and printed name of client(s): **Date: _____**

_____

_____

Signature and printed name of parent/legal guardian(s) (if necessary):

_____

_____

Signature of Therapist: _____

Initial Here:_____