Victoria Easom, M.A., LPCI
Restore Counseling, LLC
27 Gamecock Ave., Suite 202
Charleston, SC 29407
843.608.0714

Welcome

It is an honor to have the opportunity to serve you. I do not take this privilege lightly & commit to treating you with honor & respect. This document is designed to answer some FAQs about my practice & the counseling process.

Philosophy of the Therapeutic Process: It is my aim to come alongside you on your journey to wholeness; I believe that change & healing come in the context of community, that is, of relationships. Within the context of the therapeutic relationship, you are afforded the space to be seen & heard, accepted without judgment, and to wrestle with doubt & explore whatever it is that brings you here today.

While I use a variety of methods & therapeutic interventions, I primarily work from a form of narrative theoretical orientation; however, I do not hold a social constructionist belief. I do find value in using CBT interventions, Gestalt interventions, REBT interventions, & person-centered interventions. I am, personally, a believer in Christ. Should you wish to integrate faith or spirituality into therapy, I am happy to do so. However, if this is not your desire, I commit to refrain from imposing my personal belief system on your treatment. To do so would be unethical.

Please understand that you have the right to inquire about additional treatments, their risks, and benefits. If you may benefit from treatments I am unable to provide, I have an ethical obligation to assist you in seeking those treatments. Also, know that should you wish to seek the opinion of another mental health professional, I am happy to assist you in your search.

Psychotherapy is a collaborative effort, meaning that your active involvement in pursuing change is paramount for a successful outcome. Periodically, we will discuss the progress made towards stated objectives in therapy, and will work together to develop or amend a treatment plan. Therapy is hard work, and the road to health & wholeness can be a difficult journey; but, in my opinion, one well worth each step. Although there are risks involved, I believe that hard questions are worth asking and difficult things are worth the effort of reflection & contemplation. Risks associated with therapy may include experiencing uncomfortable levels of negative emotions (for example, sadness, guilt, anxiety, anger, frustration, confusion, loneliness, doubt, unpleasant memories, etc.). However, psychotherapy can be of significant benefit, bringing the client to a place of peace, health, & wholeness. This idea highlights one of the concepts behind the name, *Restore Counseling*. Restoration is a process of tearing apart in order to rebuild or repair. The process can, at times, begin to look like more of a mess than when it began;

however, once the restoration process is complete, the outcome can far surpass the former condition. This is my hope for you as we embark on this journey together.

Sessions: Sessions are typically 40-50 minutes in length. It is important for efficient, productive work in sessions that we be respectful of appointment times. Please arrive on time for your session, & understand that if circumstances cause you to be late, the session time may not be extended. I make it my practice to avoid accepting call while in session with a client. However, there may be urgent circumstances that require me to answer during our session. I typically take notes during sessions, & you may feel free to take notes as well if it will be beneficial to you. Periodically, I may ask you to complete a "homework" assignment as a component to therapy. The can be integral catalysts for change and growth. Your willingness to participate outside of therapy sessions will make our time together more productive and will assist you in reaching your therapeutic goals.

Please refer to the Financial Agreement for session fees, missed appointment fees, and methods of payment. It is my practice to collect payment at the beginning of the session so that our entire focus may be dedicated to the work at hand. Also, unless a child is the primary client, I ask that children not accompany adults to counseling sessions. If you require further clarification on this policy, feel free to inquire.

Insurance: While I do not accept insurance, you may apply for reimbursement of session fees with your insurance company. If you require assistance with this, I am happy to provide it.

Communicating with your Counselor: My mailing address is listed in the header on this document. Please understand that I cannot always be reached by phone immediately. I will respond to messages as soon as I am able during normal business hours. In the event of an emergency, if you are unable to reach me, please go to your nearest emergency room or call 911. Mobile Crisis (24-hr mental health service) may be reached at 843.414.2350. You may also receive free, confidential assistance by dialing 211.

Emergency Contact: On the "Client Contact Information" document, you are asked to list a person to be contacted in the event of an emergency. Please understand that if there is an emergency, or if I become concerned about your personal safety or the possibility of your harming someone else, I am legally & ethically obligated to contact this named person.

Treatment Progress & Termination: In order for therapy to be effective, it is imperative that we maintain the ability to communicate openly and freely about the progress of therapy. If you feel dissatisfaction with any aspect of therapy, please discuss this with me as soon as possible so that we may work together to develop a solution. Termination of therapy is inevitable and is not to be taken lightly. Together, we will work to make termination a valuable aspect of the therapeutic journey. Should

there be an instance when you would like to take a "sabbatical" from therapy, we will work together to discuss risks and benefits of such a decision.

Expert Testimony: In the event that you are involved in a divorce or custody dispute, please understand that I do not provide expert testimony in court. My recommendation is that you seek a court-appointed child custody evaluator.

Casual/Social Contact: Because of the nature of the counselor/client professional relationship, it is inappropriate for us to become "friends." It is best to avoid conflicting, dual relationships, and it is important that I maintain objectivity in the best interest of my clients. I will not see you socially, nor will I enter into any business or other relationship with you outside of the therapeutic alliance. If we, by chance, meet "on the street" or socially, I will minimize conversation so as not to risk breaching confidentiality in an open environment. I will not introduce you to anyone as "a client." You are welcome to approach me if you wish, but I will not initiate contact with you out of respect for your privacy. Please do not consider this as any form of rudeness on my part. Also, as noted in the Professional Disclosure Statement, any form of sexual behavior between counselor and client is strictly prohibited and highly unethical.

Limitations: I am not licensed or trained to practice law, medicine, social work, or any other profession; therefore, I am unwilling and incapable of offering trustworthy advice from any other professional point of view.

Non-Discrimination: I will not discriminate in accepting or treating clients on the basis of age, gender, marital status, race, religious belief or creed, ancestry, national or ethnic origin, residential location, physical or mental disability or handicap, veteran status, sexual orientation, criminal record unrelated to present dangerousness. This is a personal commitment made in accordance with federal, state, and local laws/regulations. If you feel you have been discriminated against, please bring this to my attention immediately.

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Agreement: I, _____, have read and fully understand this document, having had my inquiries satisfied. I have received a copy of this form as well as the HIPAA (Notice of Privacy Practices) document, and have been oriented to the counseling process, expectations associated with therapy, and to my rights as a client of Restore Counseling, LLC. I further acknowledge that I seek and consent to treatment with Victoria Easom, M.A., LPCI and agree to the terms outlined in this document.

_____ _____

Client Signature Date

_____

Client Printed Name

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CLIENT CONTACT INFORMATION

Date: _____

Client Name: _____

Client Address: _____

_____

_____

Client Phone: (H) _____

(C) _____

Client DOB: _____ Client SSN: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____

Relationship to Client: _____

Emergency Contact Address: _____

_____

_____

Phone: (H) _____

(O) _____

(C) _____

Client Signature: _____

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CONSENT TO ASSESSMENT & TREATMENT

I acknowledge that I have received & understand the "Professional Disclosure Statement" and "Practice Information" documents, and I affirm that any questions regarding these documents have been answered to my satisfaction.

I do hereby give consent to the therapist, Victoria Easom, M.A., LPCI, to perform assessment(s), &/or psychotherapy, &/or related treatments regarding my mental health. I understand that any information given by me may be included in my treatment record & may only be disclosed according to applicable law. I agree to be an active participant in my treatment. This includes, but is not limited to, adhering to a regular session schedule, collaborating with the therapist to develop treatment goals, & following the recommended treatment plan. I understand and attest that no promises have been made as to the results of treatment or any services provided by the therapist. I am aware that I may discontinue treatment with this therapist at any time. I acknowledge that this statement has been fully explained to me and that I understand it. My signature on this form affirms this understanding & attests to my agreement to receive therapy &/or other related treatment services as necessary.

_____ _____
Client Signature Date

_____ _____
Client Printed Name Witness

_____
Signature of Parent/Legal Guardian

My initials below indicate my understanding that Victoria Easom, M.A., LPCI does not offer 24-hr emergency service. In the event of an emergency after normal business hours (M-F, 8am-5pm), on weekends/holidays, or in the event that I am unable to reach Victoria Easom, M.A., LPCI, I agree to call 911 or go to the nearest emergency room.

_____

I, the therapist, have discussed the statements and issues above with the identified client (&/or parent/legal guardian), and, based on my observations of the above mentioned individual's behavior and responses, I have no reason to believe that this individual is not fully competent to give informed, willing consent.

_____ _____
Therapist Signature Date

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CONSENT TO INVOLVE IDENTIFIED PARTICIPANTS IN THERAPY

At times, it may be beneficial to the therapeutic process to involve significant other

participant(s) in the identified client's services. I, _____, the identified client, hereby give permission for the individual(s) named below to participate in therapy focused on my mental health. Any information offered may be included in the client's treatment record.

_____
Participant 1, Relationship to Client

_____
Participant 2, Relationship to Client

_____ _____
Client Signature Date

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FINANCIAL AGREEMENT

I agree to pay Restore Counseling, LLC the rate of $_____ per session for all counseling services rendered & acknowledge that I have been informed of the financial policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.
The only exception to this is a signed, attached payment plan developed prior to the date of service. My initials below indicate my understanding of and agreement to the following statements:

_____ The counseling session is 40-50 minutes in length & any time spent in excess of this may be billed as a separate session.

_____ A minimum of 24 hours notice is required for any appointment cancellation. My credit card on file will be charged a $30.00 fee for any missed appointment if the above notice is not given.

_____ Any services provided over the phone may be subject to the stated session rate listed above.

_____ Acceptable methods of payment include cash, certified check, or major credit card. No personal checks will be accepted.

_____ I am responsible for all charges incurred.

I hereby consent to treatment & affirm that I have read this financial agreement. Any questions regarding this financial agreement have been answered to my satisfaction & I agree to abide by these terms in full.

_____ _____
Client Signature Date

_____
Client Printed Name

_____
Signature of Responsible Party (if different from client)

_____ _____
Witness Date

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RESTORE COUNSELING, LLC
PROFESSIONAL DISCLOSURE STATEMENT

The majority of this document is mandated by both South Carolina State Law & Public Law 104-191, and is provided for your protection. Restore Counseling, LLC has tried to anticipate the risks you may face as a result of being in therapy. If you have any questions regarding any documents you have received, please feel free to discuss them with Victoria Easom, M.A., LPCI.

Personal Qualifications: I, Victoria Easom, M.A., LPCI, am a Licensed Professional Counselor Intern in the state of South Carolina. I earned my Master of Arts degree in Professional Counseling from Liberty University in Lynchburg, VA. Prior to graduate school, I received my B.A. with double majors in Bible & Humanities, a minor in English & an emphasis in Philosophy from Columbia International University in Columbia, SC. I provide counseling services for individuals, couples, adolescents, groups, & entities, covering a wide range of issues. Some areas of specialty include relationships, boundaries, stress management, Christian counseling, communication/conflict resolution, stage of life transitions, & personality/identity issues. While I use a variety of methods & therapeutic interventions, I primarily work from a form of narrative theoretical orientation; however, I do not hold a social constructionist belief. If you would like to discuss or clarify my approach to therapy further, please feel free to ask.

Fee: Payment is due at the time of service. Currently, insurance is not accepted. Restore Counseling, LLC charges a rate of $50 per session. Please consult the financial agreement for additional considerations regarding fees & billing. A sliding scale is available with proof of income and must be agreed upon in writing prior to the date of service.

Ethics: Clinicians must follow the ethical code of the South Carolina Board of Examiners for the Licensure of Professional Counselors, Marriage & Family Therapists, and Psycho-educational Specialists. Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned.

Limitations to Confidentiality: The information you share in therapy is considered protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order signed by a judge, but is considered privileged in the federal court system. I am mandated to breach confidentiality under the following circumstances if I discover that: a) you are threatening self-harm or commit suicide, (b) you are threatening to harm another individual or commit homicide, (c) a child has been or is being abused or neglected, &/or (d) a vulnerable adult has been or is being abused or neglected. Please note that if you wish your health information released to another party, you must sign a specific Release of Information form.

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Appointment Reminders and Electronic Correspondence: Often, clients express the desire to receive appointment reminders. With your permission, I will notify you of your upcoming appointment. At times, it may become efficient for us to communicate regarding various matters via suitable forms of electronic communication (email, text/SMS, etc.) However, you must be aware that such methods of communication can pose a threat to confidentiality as they are not, by nature, confidential forms of communication. If you utilize these forms of communication with me, you assume the risk that a third party may be able to intercept those messages. If you agree that you are knowledgeable about these limitations to confidentiality and if you agree to assume the risks of engaging in electronic conversation, please initial here. _____ If you consent to receive appointment reminders via text/SMS message, please initial here. _____

Informed Consent: Your signature on this document verifies that you have received this document and the HIPAA (Notice of Privacy Practices) document, that you understand these documents, and that you consent to treatment. Further, you need to be aware:

- Treatment is not always successful and may open unexpected emotionally sensitive areas.
- Victoria Easom, M.A., LPCI is not a physician and cannot prescribe medications. Be sure to discuss any concerns or side effects of medications with your physician.
- Your therapist may need to consult with your physician, attorney, or other counselor. This will take place only after a Release of Information form has been signed.
- Clinicians are licensed by the South Carolina Board of Examiners for the Licensure of Professional Counselors, Marriage & Family Therapists, and Psycho-educational Specialists. This Board may be contacted by mail at: P.O. Box 11329, Columbia, SC, 29211-1329.

Please feel the freedom to inquire for further clarification regarding this document, financial policies, the therapeutic process, or your personal progress in treatment.

I, _____, have read and fully understand this document, having had my inquiries satisfied. I have received a copy of this form as well as the HIPAA (Notice of Privacy Practices) document, and have been oriented to the counseling process, expectations associated with therapy, and to my rights as a client of Restore Counseling, LLC. I further acknowledge that I seek and consent to treatment with Victoria Easom, M.A., LPCI and agree to the terms outlined in this document.

_____ _____
Client Signature Date

_____
Client Printed Name

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NOTICE OF PRIVACY PRACTICES
IN COMPLIANCE WITH HIPAA

The purpose of this document is to inform you of how medical information about you may be used and disclosed, as well as how you may gain access to this information. Please review the following carefully.

Understanding HIPAA: HIPAA (Health Insurance Portability and Accountability Act) was passed into public law 104-191 by the federal government in 1996. According to HIPAA, all information revealed by you in a counseling or therapy session, as well as most information placed in your counseling/therapy file is considered "protected health information." The purpose of HIPAA is to provide confidential and secure protection for your health information, and to standardize billing and record keeping. Therefore, your protected health information cannot be distributed to any other party without your express informed and voluntary written consent or authorization. The exceptions to this will be outlined below.

Use/Disclosure of Protected Health Information: As required by law, I may release information without your consent. Examples of this include: law enforcement or national security purposes, subpoenas or other court orders, abuse or neglect reportings, communicable disease reporting, the review of your activities by a government agency, to avert a serious threat to health or safety or in other types of emergencies. If your written permission is given, I may use and disclose your personal information in ways other than those described above. Any granting or revoking of permission to disclose on your part must always be made in writing. If permission to disclose is revoked, any uses or disclosures made prior to your revocation cannot be rescinded. There are instances when I may need to consult with another therapist or professional about therapy cases (e.g., professional supervision as required for licensure). In these cases, I will not reveal a client's name, and the therapist/professional is also legally bound to maintain confidentiality. Should I need to contact a third party or collection agency regarding payment for services rendered, the information given would only include: name, address, dates of service, and amount to be paid.

Your Privacy Rights: Be aware that you have the following rights regarding your health information. Please note that requests must be made in writing and directed to the appropriate addresses listed in the following section.

- You have the right to view your counseling/therapy file. *Psychotherapy notes are afforded special privacy protection under HIPAA regulations, and are excluded from this right.*
- You have a right to receive a copy of your counseling/therapy file. This file copy will consist only of documents generated by the practice. You may be charged a copying fee. *Psychotherapy notes are afforded special privacy protection under HIPAA regulations, and are excluded from this right.*

- You have the right to request amendments to your records if you feel there has been a mistake.
- You have a right to receive a history of all disclosures. You may be charged a copying fee. Please note that this list will not include instances in which information was disclosed for the purposes of treatment, payment, as outlined in the previous section. This list will not include information provided directly to you or your family, or information disclosed with your authorization.
- You have a right to request limitations on the use and disclosure of your information.
- You have a right to register a complaint with the Secretary of Health and Human Services if you feel your rights have been violated.

Exercising Your Rights: Should you wish to exercise your rights under this notice, you may direct written communications to:

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If you feel your privacy rights have been violated, please direct complaints to:

Office of the Secretary
US Dept. of Health and Human Services
200 Independence Ave., SW Room
HHH Building
Washington, D.C. 20201
877.696.6775

You will not be penalized for filing a complaint.

If you would like to receive an additional copy of this notice at any time, please notify me of your request. Your signature below confirms your receipt of this document and indicated that you have read the information contain herein.

_____ _____
Client Signature Date

_____
Client Printed Name

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NEW CLIENT INTAKE FORM

PERSONAL/FAMILY RECORD:

Client Name: _____ Date: _____

Address: _____ DOB: _____

_____ Sex: _____

Email Address: _____

Employer: _____

Occupation: _____

Highest Level of Education Completed (please circle):

Some HS HS Diploma GED Some College Bachelor's Master's PhD

Marital Status (please check):
Single _____ Engaged _____ Married _____ How long? _____
Separated _____ How long? _____ Divorced _____ How long? _____
Widow/er _____ How long? _____

If married, Spouse's Name: _____

Spouse's Occupation: _____

If you have children, please list their names, age, and sex. Do they live in the home with you?

_____

_____

_____

_____

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How did you hear about us? Specify referral source if applicable. _____

COUNSELING HISTORY:

Have you ever been in counseling/therapy for any reason? **Y** or **N**

If so, when and for what reason?

_____

_____

_____

_____

How long were you in counseling/therapy? _____

Are you currently working with another Counselor, Psychologist, or Support Group? **Y** or **N**

If yes, please indicate reason & when you began?

_____

_____

_____

_____

INTEGRATION OF FAITH IN THERAPEUTIC PROCESS:

Please indicate below to describe how important faith/spirituality is in your life:

_____ Significant _____ Moderate _____ Very little _____ Not at all

Please indicate your desire for an integration of your faith/spirituality in counseling: **Y** or **N**

Comments: _____

_____

PHYSICAL HEALTH HISTORY:

Name & phone nr. of Primary Care Physician: _____

Are you currently taking any prescription drugs: **Y** or **N**

Please list any medications you are presently taking, including over the counter meds, herbal supplements, or vitamins: _____

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_____

_____

Please list any medication allergies: _____

How would you describe your physical health (please circle)?
Excellent Good Fair Poor

Are you currently seeing any other wellness professionals? (Physical Therapist, Massage Therapist, Acupuncture, Chiropractor, etc.) **Y** or **N**

If **Y**, please indicate: _____

Do you use tobacco? **Y** or **N**
If **Y**, please indicate type & frequency of use: _____

Do you drink alcohol? **Y** or **N**
If **Y**, please tell me what you typically drink, the average number of drinks consumed, and how frequently you drink.

_____

_____

Have you ever used drugs? **Y** or **N**
If **Y**, please indicate type & frequency of use: _____

Do you currently use drugs? **Y** or **N**
If **Y**, please indicate type & frequency of use: _____

Have you ever participated in any type of alcohol/drug treatment? **Y** or **N**
If **Y**, indicate name of program & length of time enrolled: _____

_____

PSYCHIATRIC/BEHAVIORAL HEALTH HISTORY:
Have you ever been admitted to an inpatient psychiatric facility, mental hospital, or other mental health facility? **Y** or **N**
If **Y**, for what reason? _____
When? _____ Where? _____

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Have you ever discussed past or current problems with a physician or other Mental Health Professional?
Y or **N**

If **Y**, please indicate dates, nature of concern, type of professional consulted, & result:
_____

Are you currently prescribed any psychotropic medications? **Y** or **N**
If **Y**, list start date, name, & dosage for each medication prescribed:
_____

Have you been prescribed any psychotropic medications in the past? **Y** or **N**
If **Y**, list start date, name, & dosage for each medication prescribed:
_____

Do you have thoughts or plans to harm or kill yourself or someone else? **Y** or **N**
If **Y**, please explain: _____
_____

Has anyone in your family been treated for psychiatric issues or been admitted to a mental hospital or inpatient psychiatric facility? **Y** or **N**

If **Y**, indicate relationship to you & your knowledge of treatment: _____
_____

Has any member of your family or any close friend committed suicide? **Y** or **N**
If **Y**, please explain: _____

Do you have a history of:	Physical Abuse?	**Y** or **N**
	Sexual Abuse?	**Y** or **N**
	Domestic Violence?	**Y** or **N**

SOCIAL HISTORY:
Where were you born? _____ Raised? _____
How often did you move as a child? _____
Is you Father living? **Y** or **N** Is your Mother living? **Y** or **N**
If **Y**, where? _____ If **Y**, where? _____

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How would you describe your relationship with your father (please circle)?
Excellent Good Fair Poor Non-Existent

How would you describe your relationship with your mother (please circle)?
Excellent Good Fair Poor Non-Existent

Who lived in your childhood household? _____
_____

Number of brothers: _____ Number of sisters: _____ Your Birth Order: _____

Are your parents divorced? **Y** or **N**
If **Y**, what was your age at the time? _____

As a student, did you struggle academically or socially? **Y** or **N**
If **Y**, please describe: _____

Did you have difficulty getting along with peers or teachers? **Y** or **N**
If **Y**, please describe: _____

Were you ever placed on probation (academic or otherwise), suspended, or expelled from school?
Y or **N**
If **Y**, please explain: _____

Have you ever or do you now experience difficulty getting along with your employer or coworkers?
Y or **N**
If **Y**, please describe: _____

CURRENT CONCERNS:
Please explain what brings you here today or the reason for your referral:

_____

_____

_____

_____

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How long has this been a problem? _____

Describe your current mood: _____

Nature of *current major stressors* (please circle all that apply):

Marital Family Financial Legal

Other(s): _____

Tell me briefly what you have been doing to address the issues that bring you in today:

_____

_____

Please circle below if you have ever experienced any of the following & indicate the age of occurrence or onset:

	Age		Age
Depression		Anger	
Worrying		Anxiety	
Fear		Panic	
Nightmares		Bed Wetting	
Blackouts		Excessive Drug Use	
Eating Problems		Excessive Alcohol Use	
Sleep Problems		Auditory/Visual Hallucinations	
Sexual Issues		Feelings of Persecution	

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Stuttering/Stammering		Reckless Driving	
Fire Setting		Thoughts of Harming Others	
Stealing		Thoughts of Harming Yourself	
Excessive Caffeine Use		Running Away	
Feeling that you are a Loner		Sexual Abuse	
Physical Abuse		Verbal Abuse	
Animal Cruelty		Irritability	