

ISI Therapeutic Family Services, LLC

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DECLARATION OF PRACTICE AND PROCEDURES

I am grateful to have the opportunity to offer services to you and hope this form will assist your decision in pursuing counseling.

Qualifications. I hold a Masters degree in Community Agency Counseling (M. Ed.) from Auburn University and I hold license #2135 as a Licensed Professional Counselor in the State of Alabama. Recently, I received a Thanatology degree (death studies) from the University of Alabama and have served as the Clinical Director for the East Alabama Critical Incident Stress Management Team, serving our communities first responders after traumatic events. My professional career started at East Alabama Medical Center where I helped plan and develop the inpatient children's psychiatric unit and then served as the children's counselor there for eight years. For the last 4 years, I have been the children's bereavement coordinator at Hospice of EAMC and am the Founder and Director of Camp Good Grief, an annual camp for children who have suffered the loss of a loved one through death.

Areas of Expertise. I provide therapy for individuals, couples, families and groups dealing with a wide range of therapeutic issues. My training and expertise provide me with abilities to assist with concern areas including anticipatory grief and post death bereavement issues, depression and anxiety, stress, behavior problems in children and adolescents, pre-marital and divorce issues, anger management, and responses to trauma. Currently, I provide therapeutic groups and individual counseling to area children who have experienced the death of a loved one, as well as provide educational/training sessions for teachers and administrative staff. It is important to note that I am not a medical physician and cannot prescribe or provide any medication. If medical treatment is indicated, the client will be encouraged to seek such attention. I will work closely with a psychiatrist or other physician if medication is warranted.

The Counseling Relationship. Each person who seeks counseling comes with unique experiences and concerns. The relationship of counselor to counselee will be characterized by professional dignity, expertise, warmth and acceptance. Therapy is a learning process and a process of change that seeks for the persons involved to better understand themselves and others as well as the interactions that occur between the participants and significant others. Equally important is to achieve enhanced functioning as an individual, couple, or family so that healthy interactions are established and greater satisfaction is attained.

Counseling has both benefits and risks. Counseling often requires recalling unpleasant events and struggling with troubling issues. Consequently, sometimes people experience uncomfortable feelings like sadness, guilt, anxiety, anger and frustration, loneliness or helplessness. However, counseling also has been proven to have benefits for people who undertake it. Often people report significant reduction in feelings of distress, improved relationships and satisfactory resolution of specific problems. Still, there are no guarantees about the outcome of counseling. My hope early in therapy is to instill trust within the client/therapist relationship. Once this foundation has been adequately established, we will develop specific goals and a plan by which these goals will be achieved. Termination of therapy will result when the client and therapist agree the goals have been achieved, at the client's request, or when another therapist might better meet the needs of the client.

Client Responsibilities. Your commitment to the counseling process indicates that you agree to make a good faith effort at personal growth and to engage in the counseling process as an important priority at this time in your life. You agree to complete assignments given or discuss any reasons for resistance. Your welfare is most important in professional counseling.

Physical Health. Psychological disorders and symptoms often have a strong correlation with medical illnesses. At times, some medical conditions require a medical differential diagnosis to determine symptom etiology. If your presenting symptoms are organic in origin, it is critical that you obtain medical treatment. Therefore, if you have not had a physical in the last year, it is recommended that you do so. In addition, prescription and non-prescription medications may have significant side effects that may be important for us to consider. I expect full disclosure of all medicines and drug intake and may request a Release of Information so that I can coordinate therapeutic services with your physician.

Confidentiality. All of our sessions will remain strictly and absolutely confidential except for the following circumstances in accordance with state law: (1) The client signs a written release of information indicating informed consent to such release. Verbal authorization will not be sufficient except in emergency situations; (2) The client expresses serious or life threatening intent to harm himself/herself or someone else; (3) there is evidence or reasonable suspicion of abuse/neglect against a minor

child, elder person (65 or older), or disabled person; or (4) a court order is received directing the disclosure of the information. Certain types of litigation (such as child custody suits) may lead to the court-ordered release of information without your consent.

Confidentiality (cont.). If you use third party insurers, such as health insurance policies, HMO or PPO plans, or EAP programs, you must sign a release of information and all information will be disclosed. In group therapy, therapist is not responsible for the actions of group members, however, all members are expected to keep all information absolutely confidential and will share no identifying information about any group member.

When working with couples, families, or groups, I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy.

Code of Conduct. I am required by state law and my own personal convictions to adhere to the Alabama Code of Conduct for Licensed Professional Counselors by the Alabama Board of Examiners in Counseling. A copy of these codes is located at the following website: www.

Emergency Situations. Since I provide outpatient diagnostic and psychotherapy services only, I cannot guarantee around-the-clock availability. Phone calls made after hours will be handled by my voice mail system and returned the following day. Therefore, if you should experience an emotional or behavioral crisis, and I cannot be reached immediately by telephone, you can contact a local medical or psychiatric hospital or call 911. East Alabama Medical Center is located at 2000 Pepperell Parkway, Opelika, AL 36801.

Fees and Length of Therapy. A detailed explanation of the fee scale is included on the fee schedule. Pay special attention to information regarding client payment, insurance payment, and appointments. According to the annual gross income of -----, the client agrees to pay----- (according to the sliding fee scale on the fee schedule) for each 45-50 minute session.

Appointments are usually scheduled one time a week for 45-50 minutes. New appointments are usually set at the close of each session, however can also be arranged on an as needed basis. Appointment times are subject to availability.

Professional Services Contract: -----(name of client) commissions Jenny Filush, M.Ed., LPC for psychotherapy. The named client understands that Jenny Filush, M.Ed., LPC offers no guarantee of cure or length of therapy, but is obligated to maintain a reasonable standard of care for a LPC. The client agrees to pay fees in full at the time of session and understands that failure to do so may result in the suspension of therapy until the balance is paid. We, the undersigned client and therapist, fully understand the terms of service outlined in this document and agree to honor them with full knowledge of all that they may entail.

Client's signature: ----- Date: -----

Client's signature: ----- Date: -----

Client's signature: ----- Date: -----

Client's signature: ----- Date: -----

Therapist's signature: ----- Date: -----

Parental authorization for minor client:

I, -----, give permission for -----

Signature of Parent or Guardian

Therapist Name

To conduct therapy with my -----,

(relationship)

Name of Minor

