INSTRUCTIONS FOR ENCLOSED FORMS

Each Client Please Complete the Following:

1. **"Contact Information" Form:** This form provides us with your contact information and allows you to specify how you would like to be contacted in the future by Holistic Mental Health Services Inc.
2. **"Informed Consent and Authorization for Services" Form:** This form summarizes important information about confidentiality, fees, cancellation policies, and other practices and policies of Holistic Mental Health Services Inc. Please review it, initial where necessary, and sign page 7.
3. **"Parental Consent for Treatment" Form:** Consent for providing treatment services to a minor is required by the parent(s) or guardian(s) of the minor.
4. **"Intake Questionnaire" Form:** This questionnaire aids assessment and treatment planning by giving your clinician a quick overview of your background and current situation at a glance.
5. **"Play Therapy Agreement for Parent(s)/Guardian(s) Form:** This form outlines what play therapy is and its benefits for your child, the practices regarding play therapy, and your role/responsibility as a parent.

Please bring these forms with you to your initial session. All information you provide in this form will be kept as part of your confidential file. Feel free to discuss any questions with your therapist before signing.

Online Therapy Clients: Please email these forms to admin@hmhscounseling.com or fax at (305) 675-7882 before your initial session. All information you provide in this form will be kept as part of your confidential file. Feel free to discuss any questions with your therapist before signing.

CONTACT INFORMATION

Printed Name: ____ Birthdate: _______________

Mailing Address:____
Street Address City State Postal Code

This must be an address to which we can send correspondence, as needed. The name "Holistic Mental Health Services Inc." will not be displayed on the envelope.

Home Phone: (_______) ____________________ May a message be left at this number? Yes No

Cell Phone: (_______) ___________________ May a message be left at this number? Yes No

Work Phone: (_______) __________________ May a message be left at this number? Yes No

Email Address: ____

Please Check One of the Following Two Statements:

I give consent to Holistic Mental Health Services Inc. to use the email above to correspond with me in all matters directly related to the provision of services (includes invoicing; appointment bookings, confirmations and reminders; follow-up on services; invitations to complete feedback surveys, etc.), with the exception of automatic, system-generated emails if I have opted out of receiving them on page 4 of the Informed Consent. This consent also applies to any new or updated email address that I provide to Holistic Mental Health Services in the future.

I have not provided my email address in this consent form, but I understand that if I were to send an email to Holistic Mental Health Services in the future, making an inquiry, I am giving implied consent to Holistic Mental Health Services to respond to that email, as often as needed, in order to address my inquiry.

Would You Like to be on Our Email Newsletter List?(Please Check One of the Statements below):

Our monthly newsletter contains articles on building strong relationships and mental and emotional wellness, links to online resources and book recommendations that you can use to improve your situation, and notices of upcoming workshops or new services.

Yes, I would like to receive monthly email newsletters from Holistic Mental Health Services

No, I do not wish to receive monthly Associates (using the email address above) newsletters

Referral Source:

Please let us know how you learned about Holistic Mental Health Services Inc.

Internet search / website

Word of mouth (family/friend)

Another professional (physician, lawyer, etc.)

Workshop or seminar

I am a returning client

My employer or health insurance provider

Other ___________________________________

YOUR SIGNATURE ____ __________________
Signature Date

INFORMED CONSENT AND AUTHORIZATION FOR SERVICES

Welcome to Holistic Mental Health Services Inc.

This form provides information about the practice and privacy policies of Holistic Mental Health Services Inc. This information is intended to help you make an informed decision about accepting services from us. If you have any questions or concerns about anything on this form, please do not sign the form until you have discussed your concerns with your professional partner. Within each section, a summary of the essence of that section is **highlighted in bold.**

Frequency of Sessions?	**Weekly or bi-weekly 50-minute sessions are most common. The frequency of sessions is based largely on your needs and situation.**
How long is therapy?	The amount of sessions needed varies depending on the nature of each person's concerns, the complexity of the issues involved, the strength of our working relationship, and each person's commitment to work on the presenting issues. There is a direct relationship between effort applied between sessions and progress over time. Anywhere between 1 and 20 sessions is typical, though more sessions may be needed in some situations.
Fees	• **$100 per 50-minute hour face-to-face sessions** • **$75 per 50-minute hour e-therapy sessions** • Additional time beyond the 50-minute hour is billed in 10-minute increments. • Billable services include: face-to-face and telephone consultations (not including the initial intake or dealing with brief scheduling matters), report writing and other requested correspondence, and review of written records from other professionals. • **Fees are payable by cash, check, credit card or debit**
About Privacy	• **All information you share with your professional partner is private and confidential.** • **Your information will not be released to anyone without your written permission (with some exceptions as explained below).** • When information is to be released with your consent you will be consulted regarding what information is to be released. • Your information will be kept on file in a secure and private location. • You may review the contents of your own counseling file upon request. • The full privacy policy for Holistic Mental Health Services Inc. is available upon request.
Exceptions to Privacy	**A client's confidential information may be released without their consent under the following conditions:** • When the purpose is t**o protect individuals (including a client) who are at foreseeable and imminent risk of bodily harm or death** as a result of a client's actions. • Under law that requires **reporting of child and elder abuse/neglect** to authorities. • **Under subpoena from a court of law.** • In the unlikely event of a client's account becoming 120 days past due or in the event of a dispute over a financial transaction, limited information may be shared with financial or legal agencies connected with the business of Holistic Mental Health Services Inc. (i.e. credit card companies, collection agencies, etc.)**as necessary to resolve such**

	disputes or to collect on unpaid accounts. In such cases, any personal information disclosed is limited to only that which is necessary to resolve the dispute or to settle the account (i.e. dates, transaction amounts, etc.) and does not include any clinical information. • There are exceptions to confidentiality that apply to personal information disclosed by minors. Your professional partner will discuss these with you in session, as applicable. • If you disclose in confidence that you have done something illegal, your professional partner is not obligated to report this to the authorities, unless the circumstances involve child abuse, abuse against a dependent adult, or a direct threat to another person (as outlined above).
Email Privacy	• Email is a quick and convenient method of communication. Many of our clients use it to correspond with us. Please be aware, however, that while every effort is made to safeguard your privacy, we cannot guarantee the confidentiality of email messages. If this is a concern for you, please do not use email to correspond with us. • **We will only use email to communicate with you: a) in response to an email you send us, or b) as you authorize it or otherwise request it.**
Collaboration with Professional Referral Source ***Enter Referral Source Name*** →	• If you have been referred to Holistic Mental Health Services Inc. by another professional (i.e. mental health provider, lawyer, physician, psychiatrist, clergy, etc.), **it is customary for your professional partner to contact your referral source** to acknowledge the referral at the beginning of treatment. • **Your signature at the bottom of this form is your consent for this communication to take place.** If you do not give your consent for this communication, or if this is not applicable to you, please leave this section blank. • If Applicable:____ *Name of Professional Referral Source* *Phone (If Available)*
Consent to Release Information to Health Insurance Provider	• **If you will be submitting any health claims for reimbursement** to your health insurance provider for the counselling services you receive at Holistic Mental Health Services Inc. **your health insurance provider may contact us to obtain information necessary to verify your claim.** • The type of information they would typically request includes: 1) date of service, 2) the nature of services provided, and 3) the names of individuals who received the service. • Our experience has shown that verification checks are not common, and that most health insurance providers will typically not request detailed diagnosis and treatment plan information, unless the insurance company was the referral source who previously contacted us on your behalf, and contracted with us to provide services to you. • **Your signature at the bottom of this form is your consent for this communication to take place, if necessary.** If you do not give such consent, please cross off this paragraph. • If you are not submitting any claims, check the box marked "Not applicable" below.
Enter Insurance Company Name →	If Applicable:_______________________________. Not applicable *Name of Health Insurance Company*
24-Hour Cancellation	• **If you cannot attend an appointment, please notify our office**

Policy	**24 hours in advance.** • **Please cancel by email to have a record of your cancellation.** • The purpose of a 24-hour cancellation policy is to allow enough time for us to fill the vacant appointment slot, thereby meeting the needs of other clients who are waiting for an appointment. The professional partner is essentially committing a one-hour (or longer) block of his or her time to a client's care, and only a limited number of such appointment slots can be booked in a day. A same day cancellation provides insufficient notice with which to re-book an appointment, and thus represents both lost opportunity for someone else to benefit from that time slot as well as lost revenue.**There is, therefore, a fee charged for a late cancellation or missed appointment of $85 for a 50-minute missed appointment**(pro-rated in the event of a longer appointment slot). • We appreciate that unforeseen events sometimes happen, but please be as respectful of our time as you can. Exceptions to this policy are rare. • Please be aware that third-party reimbursement providers (i.e. health insurance companies) typically do not reimburse for late cancellation charges or no show charges. • If you provide your email address or your mobile number to our scheduling system you can request an email or text message reminder notification about your appointment. Please note that these reminder notifications are a courtesy only.**Our clients are fully responsible for any appointments they have booked with Holistic Mental Health Services Inc. even if they receive no reminder notification.** • If you arrive late, the session will have to be shorter but will still be billed as though you had utilized the entire hour. • If you are more than 20 minutes late, we will assume you are not attending.
Initial Here →	*I am aware of and agree to pay the late cancellation/missed appointment fee in the event that I cancel an appointment with less than 24 hours notice. I am aware that the charge is $100.00 for a one-hour appointment* ______________________. Initials
Initial Here →	*I understand that a notification to cancel initiated after hours (i.e. after 4:30PM or on weekends or statutory holidays) for an appointment scheduled the following business day is considered a late cancellation regardless of the length of notice.* ______________. Initials
Social Media	**It is the policy of Holistic Mental Health Services Inc. not to accept social networking invitations from past or current clients utilizing social media sites** such as Facebook,Linkedin or other similar sites. • This policy is in keeping with ethical guidelines that prohibit the formation of dual relationships between professional partner and client. A dual relationship occurs when a professional partner and client form another type of relationship outside of the professional partner-client relationship (i.e. mutual friendship, business associate, teacher, student, family member, etc.), or enter into a professional partner-client relationship after another type of relationship has already been established. Such dual relationships have the potential for creating conflicts of interest, possible exploitation, and problems associated with unhealthy boundaries.

Feedback Surveys	• Holistic Mental Health Services Inc.**utilizes a client-directed feedback system** to provide us with feedback about the effectiveness of our services. This system **consists of a number of surveys that we ask clients to complete during the process of therapy and at termination of therapy.**We use the information from this feedback system to help us determine if the counseling we are providing is effective in helping you, specifically, as well as gaging the effectiveness of our clinic as a whole. • If you have provided your email address to the online scheduling system, you will receive an automatically-generated "Thank-You" email after each session containing links to these feedback surveys that are completed online. • **We ask that you consider completing these surveys to help your professional partner know what is working well in counseling, and whether anything can be adjusted in the way your therapy is conducted to help you achieve your goals.** • These surveys are voluntary; there is no obligation to complete them. • There are three types of surveys: 1) a brief, post-session survey that you complete after each session, 2) a more in-depth survey that you complete after every 3-4 sessions, and 3) a final termination survey to be completed after your final session. • Up to six months from your last session, if you have previously given express consent to Holistic Mental Health Services Inc. to use your email address (on the contact form you filled out), we will manually send you a follow-up email inviting you to complete a brief, anonymous feedback survey, with no personal identifier linking you to your responses. Again, this survey is voluntary. • All of these surveys are confidential. Only your professional partner and the director of the clinic will have access to your specific results. We do ask that you provide an identifier, known only to you and to your professional partner, in each survey so that your professional partner can identify you. • Over time, the aggregated numerical results of surveys for the clinic as a whole, minus specific written comments and any other identifying information of specific individuals will be available to all clinic staff. • **If you do not wish to receive any of the automatic, system-generated emails, we ask that you please delete your email address from the scheduling system or request that we delete your email address for you. You can do so by signing your initials below where indicated. Be aware that this will also discontinue appointment confirmations and appointment reminders by email.**Unfortunately, there is no way for us to delete the follow-up emails while retaining the ability to send you appointment confirmations and appointment reminders. • **If you wish to participate in this feedback program, but do not wish to complete the surveys online, please inform your professional partner and arrangements can be made to have you complete the surveys in hard copy.** • Your signature at the bottom of the form constitutes your consent to receive the system generated surveys by email, unless you have signed your initials immediately below.
Initial Here ONLY if You Wish to Opt Out of the Follow up Emails	*OPTIONAL: Please remove my email address from the Holistic Mental Health Services Inc. scheduling system. I understand that this will not only stop the automatic follow-up / feedback survey emails from being generated, but will prevent any appointment confirmations and*

→	*appointment reminders from being sent to me by email.* ___________. Initials
Credentials	Associates of Holistic Mental Health Services Inc. have at least a master's degree in psychology, marriage and family therapy or social work and are registered through their governing professional body (i.e. Florida Board *of* Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling) as registered psychologists, registered provisional psychologists, registered mental health counselors, registered marriage and family professional partners, or registered clinical social workers.
Emergencies	• If your life or safety is in danger please phone 911 or go to the nearest emergency room. • For other emergencies a useful resource is the **Jackson Behavioral Health (24 hours)**at**(305) 585-1111**. Non-urgent concerns should be reserved for a scheduled appointment. • You can also call our office at**(305) 330-4550**. Be aware, however, that your professional partner may not always be available, particularly after hours, and may not be able to return your call immediately.
Complaints and Questions	• It is important to us that you feel you are benefiting from the services you are receiving. If at any time you are unhappy with the service you are receiving or if you are unsure about the goals or purposes of treatment, please express your concerns to your professional partner directly. We will do our best to resolve your concerns and answer your questions. • If you would prefer, your professional partner will also assist you with a referral to another professional. • If we can improve the service you are receiving in any way, please let us know.

YOUR SIGNATURE

I have read this letter in full, and I have been informed of the procedures and conditions as outlined in this letter. I have had an opportunity to discuss these procedures and conditions with my professional partner and I am satisfied that my questions have been answered to the extent possible. I accept the help offered with full knowledge and understanding of the relevant procedures and conditions.

____

Name Signature Date

PARENTAL CONSENT FOR TREATMENT-page 1

AGREEMENT REGARDING MINORS

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Occasionally, it is best to see them with parents and other family members; sometimes, they are best seen alone. I will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential, as well as their understanding of the basic procedures involved in counseling children.

This general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of the overall development, they may not be the best goals for therapy. Again, I will evaluate and we will discuss these goals together.

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

This agreement regarding treatment of minors has provisions for inserting details, which can be supplied by both the child and the adults involved. However, it is first important to point the exceptions to this general agreement. The following circumstances override the general policy that children are entitled to privacy while parent or guardians have a legal right to information.

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.
- Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child.
- Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that I do not have control over information once it is released to a third party.

Now that the various aspects surrounding confidentiality have been stated, the specific agreement between you and your child/children follows:

Parent/Guardian Understanding & Agreement

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/ children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details.

The normal procedure for discussing issued that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present. When the therapist determines that there are significant issues that should be discussed, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

PARENTAL CONSENT FOR TREATMENT- page 2

I/we, ____ and ____,

Consent to ____, providing counseling services to:

(Name of minor/dependent adult)	(Date of Birth)
(Name of minor/dependent adult)	(Date of Birth)
(Name of minor/dependent adult)	(Date of Birth)
(Name of minor/dependent adult)	(Date of Birth)

Please select the appropriate custodial arrangement that applies to your situation:

Check one:

Biological parents residing together
-Consent for treatment form can be signed by one biological parent

Biological parents not residing together – sole custody agreement
-Consent for treatment form must be signed by the parent with sole custody

Biological parents not residing together – joint custody agreement
-Consent for treatment form must be signed by *both* biological parents

(Signature of Custodial Parent/Guardian)	(Date)
(Signature of Custodial Parent/Guardian)	(Date)
(Signature of Witness)	(Date)

Intake Questionnaire Child- Page 1

Today's Date:____

Child's Name: ____

Child's Birthdate: ______________________________ Age: ______

Child's Biological Mother: __________________________________

Child's Biological Father: __________________________________

Does your child:
Have any medical problems? Yes No
If yes, please list them: __________________________

____

Do you take any prescription Medications? Yes No
If yes, please list them:

Medication	*Dose*	*Purpose*	*Since*

Child primarily Resides with:
- Biological Mother and Father in the same house
- Biological Mother
- Biological Father
- 50/50 Biological Mother and Father

Name of School: ____

Grade Level: ____

Average Grades: Math: ______________________________________

Science: ___________________________________

L.A.: ______________________________________

Social Studies: ____________________________

Do any **Extracurricular** Activities? Yes No

If yes, please specify: _____________________________

____

Are you concerned that your child is using alcohol and/or illicit drugs? Yes No

Does your child have a job? Yes No

Current Job: ____

Years at current job: ________________ Hours per week: ________

Has your child ever threatened self-harm? Yes No

If yes, when and explain? ______________________________

____

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1= a little, 2= moderate, 3= a lot, 4= extreme) rate how much you have observed each symptom in your child over **the past two weeks.**

(Circle a number)

	Symptom					
1.	Feeling sad, down, or depressed	0	1	2	3	4
2.	Avoiding certain people or places	0	1	2	3	4
3.	Loss of interest in activities I normally enjoy	0	1	2	3	4
4.	Low energy/feeling tired	0	1	2	3	4
5.	Sleep problems (insomnia, hypersomnia, not staying asleep, or early waking)	0	1	2	3	4
6.	Eating too much or too little	0	1	2	3	4
7.	Not able to think clearly	0	1	2	3	4
8.	Feeling no pleasure or joy in life	0	1	2	3	4
9.	Anxiety Attacks	0	1	2	3	4
10.	Worrying about things	0	1	2	3	4
11.	Angry outburst	0	1	2	3	4
12.	Low self-esteem or low self-confidence	0	1	2	3	4
13.	Feeling guilty	0	1	2	3	4
14.	Feeling too stressed	0	1	2	3	4
15.	Thoughts of suicide	0	1	2	3	4
16.	Drinking too much or abusing drugs (i.e., street drugs or prescribed medications)	0	1	2	3	4
17.	Acting out other compulsive behaviors (I.e., gambling, sex, porn, shopping, etc.)	0	1	2	3	4
18.	Not getting my work done	0	1	2	3	4
19.	Feeling unhappy with my workplace	0	1	2	3	4
	Symptoms Total:					**/64**

How much do these symptoms interfere with the following?

Area					
Personal Well-being	0	1	2	3	4
School Performance	0	1	2	3	4
Family Relationships	0	1	2	3	4

PREVIOUS TREATMENT

Has your child participated in therapy or counseling in the past?

Yes No If yes, please specify:

Date	Duration	Therapist/Location	Was it Helpful?

EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL/HEALTH DIFFICULTIES

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

	Who? When?
Depression	
Bipolar Disorder	
Schizophrenia	
Other psychiatric disorders (i.e. psychosis, hallucinations)	
Suicide	
Physical/Sexual Abuse	
Substance Abuse (Alcohol/Drugs)	
Autism Spectrum Disorder	
Eating Disorder	
Chronic Illness (please specify illness)	
Accidental or Untimely Death	
ADHD or Learning Disorders	
Other	

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your professional partner to know:

____

____

____

____

____

Play Therapy Agreement For Parent(s)/Guardian(s)- Page 1

The following is an explanation of play therapy and the therapeutic process. As you read this information, you may want to make some notes so that you can refer any questions to your child's play therapist.

Importance of play for children:

- Play is the child's natural way of communicating.
- During play, children learn about their physical surroundings, their own capabilities and limitations, social rules and the difference between fantasy and reality.
- Play promotes healthy development in children.
- Children can often communicate their difficulties more effectively through play than they can through language.

What is play therapy?

Play therapy is to children what "talk therapy" is to adults. When adults have problems, it often helps if they can share their thoughts and feelings with a therapist or trusted friend. Children don't have the ability to express themselves with words like adults do, so it is difficult for them to "talk" about things that worry or bother them. Play therapy allows children to communicate through play, their most natural form of expression. The toys the children use in play therapy help them play out what they may be feeling, what they have experienced, and what they would like to be different. This experience enables them to attach words to their experiences, leading to a release of emotions and further recovery for the child.

Why does my child need play therapy?

In the process of growing up, most children experience difficulty coping at some time (at home, in school, with divorce/separation, with socialization, as a result of trauma or abuse, etc.), or they exhibit behaviors which concern their parents or teachers. Generally, if you, your child's teacher or a physician is concerned about your child's behavior or the difficulty of adjusting, play therapy is the recommended approach to helping your child.

What can I expect from play therapy?

There is much more freedom in the play therapy room than is allowed in other areas of the child's life. During the therapy time, every thought and feeling and almost all actions of the child are accepted. This freedom is necessary so that the child will feel accepted, safe, and trusting enough to reveal their fears and problems. There is no such thing as wrong or bad behavior in play therapy. In play therapy, the therapist will not "pump" the child for information about their life or an abusive incident. Children are allowed to work through their problems at their own pace. In play therapy, children may spill paint, sand or other messy materials on themselves. (Remember, there are few limits here). Therefore, you are encouraged to bring your child in play clothes.

What do I tell my child about play therapy?

Before the child comes in for their first session, they will need to know something about play therapy. You can tell them that they will be coming to a place that has a special room with toys. Tell them that they will be meeting a grown-up named , who will be taking them to the playroom and staying with them there. It is helpful to let them know they will be coming back every week, that this is not just one visit. If your child wants to know more about why they are coming, you may say something like, "when things are difficult for you at home, school, in the family, etc., sometimes it helps to have a special place to play and a special person to help." You may also tell them that it is okay to talk about those things in the playroom with the therapist. It helps if you can arrive a few minutes early for each appointment and take your child to the bathroom. Reassure your child that you will be waiting for them when the session is over.

Play Therapy Agreement For Parent(s)/Guardian(s)- Page 2

When do you get to talk to the therapist?

It is very helpful for the therapist to know about recent and past events in your child's life, especially those to which your child has reacted strongly. Please do not give your child the responsibility of reporting the events. The play therapy session is a very special time for your child; therefore, the therapist will spend most of the time (40-50 minutes) with your child. If you need to talk to the therapist, please do so in the First 5 minutes. The therapist or you may initiate a parent consultation every four weeks or as important issues arise. Parent consultations are times for you and the therapist to share information about your child and the therapist may make recommendations at this time. If you have concerns that need to be addressed in between sessions, please let the therapist know by calling the office.

After each session:

It is essential that your child does not feel the need to give an account of what happens in the play therapy room. Therefore, it is helpful if you do not ask your child if he/she had a good time or what they did. When your child meets you in the waiting room following a session, you might say something, like "Oh, I see that you are done. Are you ready to go?" It is fine if your child chooses to volunteer information, but allow them to lead the conversation. Your child may occasionally bring home are work. This may depict a hidden meaning or message that even your child may not be aware of. Therefore, it is best not to offer praise, ("How pretty!"), criticize or ask questions. IF your child offers their picture, simply comment on the colors they used or what you see. "You covered the whole page with blue."

How often and how long will my child need to come?

Children grow and develop best when they have structure and consistency. Therefore, in order for play therapy to be helpful, it is imperative that the sessions be consistent, that is at least once a week and preferably on the same day and time. Play therapy is a process of the therapist building a trusting relationship with a child, the child revealing and/or working through their problems, coming to a resolution, practicing new skills and preparing for termination.

Every child grows and changes at a different pace, therefore, the length of time needed in play therapy will vary according to individual personalities, severity of trauma and home and life circumstances. Generally, you can expect a minimum of 16 sessions (4 months). Behavior and mood changes are normal and expected throughout the process of play therapy At times, it may seem as though things are getting worse and not better. If you notice this happening, please talk it over with your child's play therapist.

OTHER HELPFUL INFORMATION:

In order to provide the best service possible, it may be necessary for the play therapist to consult with other professionals that have worked with your child, i.e. school, teachers, school counselors, social workers, psychologist, psychiatrist, attorneys, etc. Permission will be obtained from you in writing before communication can be shared with other professionals and/or individuals outside of the Holistic Mental Health Services.

If needed, the play therapist may refer your child for group therapy, psychological and/or psychiatric assessments or other types of therapy. You play a crucial role in your child's life and are a member of the therapeutic team for your child. Therefore, it may at times be beneficial for you to explore some of your own issues. Referrals may be made for you to parenting classes, individual or group therapy, self-help programs or other areas as necessary.

It is the policy of Holistic Mental Health Services that parents remain at the office during the child's session. Additionally, children under the age of 12 may not be left unsupervised in the waiting room.

(Signature of Custodial Parent/Guardian)	(Date)
(Signature of Custodial Parent/Guardian)	(Date)
(Signature of Witness)	(Date)