Turning Point Professional Counseling
Lynda Griffin Bull, LPC, PLLC
10505 N. 69th St. #200
Scottsdale, AZ 85253

Phone: (480) 707-7406 www.scottsdale-therapist.com

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

Professionals Include:
Lynda Griffin Bull, LPC

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Lynda Griffin Bull, LPC offers a wide array of counseling services, including individual, family, couples, and group services. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is my intent to convey the policies and procedures used in this practice, and I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: I provide counseling services designed to address many of the issues clients are dealing with. Your first visit will be an assessment session in which you and I will determine your concerns, and if both agree that Lynda Bull can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Lynda Bull, services to you may be terminated.

My goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and I are not a good fit, please discuss this matter with me to determine if transferring to a more suitable Therapist is right for you. If you and I decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide my clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. If you must cancel or reschedule your appointment, I ask that you call my office number at 480-707-8406 at least 24 hours in advance, whenever possible. This will free your appointment time for another client.

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$195_____
	Regular Office Visits (50 minutes) (Individuals, Couples & Play Therapy)	$130_____
	Family Sessions (90 minutes)	$195_____
	Outside Office Work (inpatient visits, court, collaborative law services)	$130_____
	Written Reports (insurance companies, supervisors, etc. pro-rated at	$ 25_____
	Returned check fee per check	$ 25_____

A reasonable fee will be charged for copies of any records requested by the Client.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact me at 480-707-7406 regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, please call on the same number; 480 707 7406. Please utilize this number in an event of an emergency and I will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When I am out of town, you will be advised and given the name of an on-call Therapist.

CONFIDENTIALITY: Lynda Griffin Bull, LPC follows all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of Lynda Bull, LPC, in order for us to discuss this matter further. By signing this Information and Consent Form, you are giving consent to Lynda Griffin Bull, LPC to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless Lynda Griffin Bull, LPC from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If I believe that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Lynda Griffin Bull LPC to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to Lynda Griffin Bull, LPC to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
_____	_____
_____	_____

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to

the child's mental health care and treatment, Lynda Griffin Bull, LPC will not render services to your child until I have received and reviewed a copy of the most recent applicable court order.

_____	_____
Signature – Client/Parent	Date
_____	_____
Signature – Spouse/Partner/Parent	Date
_____	_____
Therapist	Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____	_____
Client/Parent	Date

I authorize the payment of medical benefits to the provider of services.

_____	_____
Client/Parent	Date