Alyssa Teitsma
M.Ed., Resident in Counseling

Welcome! Thank you for selecting me as your therapy provider. I will do all I can to offer you the highest quality care possible. The purpose of this agreement is to provide you with important information about my background, the counseling process and your rights and responsibilities. Counseling is more likely to be successful if we have a mutual understanding of the treatment process.

I work with children, adolescents and adults and provide ongoing family support when needed. I work predominantly with children and their families, and have experience helping with mood disorders, anxiety, school concerns, and relationship problems. During our first few sessions, we will begin to establish trust, and work together to outline goals for treatment as well as a plan that will help you achieve these goals. In my experience, counseling is most effective when provider and client work collaboratively. Treatment will be most beneficial when you come to sessions on time, at the agreed upon frequency, complete any tasks or exercise agreed upon, and speak openly and honestly during sessions about your concerns, behaviors, thoughts, and feelings that are bothering you.

Although counseling usually results in positive changes in mood, behavior, relationships and other areas, it may also lead to unanticipated and unwanted changes. If anything about our counseling troubles or disappoints you, I strongly encourage you to talk about that in our sessions so that we can address your concerns.

Below is some more information that might answer your questions as you inquire about working together with me.

Credentials, Education and Experience:

I am a resident in counseling in Virginia and a licensed school counselor (K-12) in Virginia. I completed my undergraduate degree at Christopher Newport University with a degree in Psychology in 2008. I earned my Masters in Counselor Education from The University of Virginia in 2011. I have 12 years of experience as a school counselor with Fairfax County and Prince William County Public Schools where I have worked across the K-12 setting. I have extensive experience working with school aged children and their families on a variety of topics, including anxiety, coping skills, social skills, and conflict resolution. I am working in private practice and am receiving counseling supervision from Dr. Michael Greelis, while I work towards fulfilling residency hours towards my LPC.

487 B Carlisle Drive, Herndon, Virginia 20170-4899
703.679.7628 (voice/text) – atcounselingva@gmail.com

Confidentiality Statement:
All client records are treated confidentially based on legal and professional standards pertaining to counseling practices. These records will not be released without the written consent of the client (and/or parent/guardian, in the case of a minor). Exceptions to confidentiality can ensue: (1) when you do or say something that threatens your safety and/or suicide; (2) when you do or say something that threatens the safety of others and/or homicide; (3) when there is known or suspected child or elder abuse; (4) when records are court ordered compelling disclosure. Your counseling services may become part of discussions with a clinical consultant in which case your confidentiality will be maintained. In addition, if you file for insurance or have me do so, the diagnosis on the claim will be known by the insurance carrier.
Policies on protected health information as per Virginia law and HIPPA are explained http://tinyurl.com/yd3rsdbw or here https://mgbhcounseling.files.wordpress.com/2016/09/greelis-va-and-hipps2.pdf or on the main menu of the website https://mgbhcounseling.com/

When working with minor clients, it is important that there is trust between provider and client. Please note that parents/guardians will not be given detailed information regarding session information unless minor client provides consent. This ensures trust for a safe working therapeutic relationship. Should minor child be in direct threat of suicide or death parent/ guardian will be notified immediately.
I do not accept friend requests from clients on social media platforms because it may jeopardize your confidentiality.
_____. (initial)

Financial Policy: Fee for services is $125 for 50 minute individual or parent session; Payment is due at the time of treatment; by cash, check or square payment.
_____ (initial)

Should you request my presence at any meeting related to your child's treatment (such as an IEP or relevant school meeting, meetings with other mental health professionals, or classroom observations), you will be billed a flat rate of $125 for the initial hour and $85 for each additional hour.
_____ (initial)

It is my policy not to testify in court unless subpoenaed. If I am compelled to testify, my fee for services related to court (such as preparation, consultation and report writing) will be discussed with you in advance and must be paid in advance. Fees are applicable regardless of party pursuing the subpoena.
_____ (initial)

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Cancellation Policy:

If you need to cancel or change an appointment, please give me at least 24 hours notice. If that is not done, you will be charged the full session fee for any missed appointments. Appointments can be made up within the week, contingent upon my availability. Emergency Cancellations (within 24 hours) due to a family emergency or some other unforeseeable infrequent circumstance should be made to my cell number, and may incur a fee. These appointments will be offered a courtesy reschedule, contingent upon my availability. Please be aware that insurance companies do not make payment for missed appointments. (You will not be charged for weather-related cancellations if your base school is closed due to the weather at the time of your appointment). I do my best to provide you with a routine day and time for recurring appointments. Please note that if you miss three consecutive routine appointments, I may not be able to hold your regular appointment day and time and you may be asked to reschedule your appointment rotation.

_____ (initial)

Contact and Emergencies:

If you are experiencing an emergency that is not life-threatening, please leave me a detailed message and I will return your call as soon as possible. **If the emergency involves a life-or-death situation or threat of physical harm, contact me AFTER calling 911 and your psychiatrist's emergency number (if you have one) or proceed to the nearest hospital emergency room**. These could include the following 7 day a week, 24 hour a day numbers: 911 (any area); Colombia Dominion Hospital, 703-536-2000; Fairfax/Falls Church Community Mental Health Center at Woodburn, 703-573-5679; or Inova Fairfax Hospital 703-698-1110. Please do not use email or text for emergency situations.

_____(initial)

I am the child's parent/legal guardian, and I am authorized to seek treatment for him or her. I authorize group and/or individual psychotherapy for my child. I also acknowledge receipt of the information in this document including Virginia law and HIPPA regulations for protected healthcare information here http://tinyurl.com/yd3rsdbw **or here** https://mgbhcounseling.files.wordpress.com/2016/09/greelis-va-and-hipps2.pdf

Client Full Name: _____ Client DOB: _____

Signature: _____

Please print name: _____Date: _____

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Informed Consent:

- I acknowledge that I have received and read (or have had read to me) the 'counseling agreement'.
- I do seek to take part in treatment with Alyssa Teitsma, Resident in Counseling, and consent to treatment.
- I understand that no promises have been made to me as to the results of the treatment provided.
- I am aware that I have the right to discontinue treatment at any time during the counseling process.
- I understand that I am responsible for payment at the time of service and that payment must be made directly to my provider. I know I am responsible for any outstanding balances, missed appointment times, and/or other fees incurred related to phone calls, document preparation, attendance of meetings at my request, and court related charges.
- I am aware of and understand the cancellation policy for Alyssa Teitsma, Resident in Counseling.
- I understand that if payment for services is not made, Alyssa Teitsma, Resident in Counseling, has the right to discontinue services.
- I acknowledge the confidentiality guidelines that are outlined in the 'counseling agreement' and understand the exceptions to these guidelines.
- I am aware that if I choose to use a third party agent (insurance company) for reimbursement, that agent may be given information about the type, cost, and dates of services received. **I authorize the release of any information relevant to this claim.**
- I understand the limitations of confidentiality as it relates to technological communication such as fax, cell phone, or email; and should that be a chosen form of communication, **I accept the limitations.**

My signature below shows that I understand and agree to the above information.

_____ _____

Signature of Client/Custodial Parent/Guardian Date

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