Manifest Counseling Collective

Kambra Meyer, MA, LPC, LCAS – 383 Merrimon Ave., Suite C - Asheville, NC 28801- (828) 367-7077 - kambra.meyer@gmail.com

Photo/Artwork Release Form

AUTHORIZATION TO USE PHOTOGRAPHS OF AND/OR ARTWORK CREATED IN SESSION

I, ____ (client), hereby authorize ________________________________(Kambra Meyer, MA, LPC, LCAS, Art Therapist), the Manifest Counseling Collective (Agency), or ____________________________________ (other individuals under Kambra Meyer's supervision) to, without compensation, use, reproduce, and/or publish photographs of artwork that may pertain to me— ***not*** including my image, likeness and/or name. I understand that this material may be used in various publications, research contributions to the field of mental health and art therapy, or for related presentations, supervision of other art therapists, and other professional endeavors. This material may also appear on the Internet Web Page of the Therapist, Agency, or Supervisee. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, the Therapist, Agency or Supervisee may publish materials, photograph, and/or make reference to my artwork in any manner that the Therapist, Agency or Supervisee deems appropriate in order to educate/promote/publicize art therapy services offered. Any identifying information will be excluded and strictly protected under HIPPA privacy and confidentiality standards.

Optional Description of Materials (Photos/Artwork):
____

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____ Signature of Artist

_____________Date

____Witness Signature

____________ Date

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Informed Consent for Energy Psychology Methods Including Advanced Integrative Therapy (AIT), Eye Movement Desensitization and Reprocessing (EMDR), and Emotional Freedom Technique (EFT)

Please read over the following information and discuss any questions you have prior to signing.

I have been advised and understand that a component of the treatment I will receive may utilize an applied kinesiology technique called “muscle testing” and involve work with “energy centers” or “chakras” or “meridian points”.

Muscle testing (also called “energy checking”) is an assessment tool for determining how energy patterns affecting the body and mind may be related to the problems I wish to address in pursuing treatment with my psychotherapist. The technique involves my psychotherapist applying physical pressure, such as a light downward pressure on the wrist, that will determine if a specific muscle stays firm or loses strength when I bring to mind a particular thought, emotion, or problem state and resist the pressure. The outcome, as indicated by the relative firmness maintained by the muscle, provides information to both my therapist and me about emotional dimensions of my problems that may not be available to me through introspection. Based partially on this information, my therapist will advise me on which energy centers may best be used in helping me achieve my treatment goals.

Energy centers, adapted from the practices of acupressure and yoga, are located on the surface of the skin throughout the body and can be stimulated for the purpose of correcting disturbed energy patterns that might include touching, rubbing, or tapping the center. In most instances, I will be instructed how to stimulate the appropriate points myself. In rare instances, my therapist may ask my consent to directly work with specific treatment centers.

I understand that the use of muscle testing and energy treatment points within the field of psychotherapy is a relatively new development and that, at this time, there is only limited published research in established scientific journals investigating these methods. While clinical reports for successful outcomes using these methods do exist in the published literature of the field known as energy psychology, and the methods are being developed and refined under the auspices of organizations such as the Association for Comprehensive Energy Psychology, I understand that clinical reports do not constitute conclusive scientific evidence. I further understand that even if the clinical effectiveness of these methods is scientifically established, results will vary from person to person.

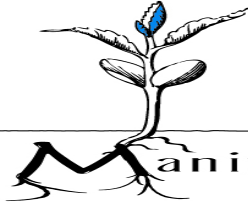
I understand that with particular therapeutic techniques such as AIT, EMDR, and EFT, my therapist may model on her physical body or ask consent to lightly touch non-triggering and non-threatening areas of my physical body in order to best offer these services. I understand that consent will be granted each and every session and that I may revoke consent for direct physical touch at any point, and that my comfort will always be honored.

____ Signature of Client

_______________Date

____Witness Signature

______________ Date



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Authorization for Release of Information

Name:___________________________________ DOB: ________________SSN:___________________

I authorize Kambra Meyer to: ___ Obtain records from ___ Communicate/ share information with ___ Send records to

Name of person/facility:_________________________ Phone Number:____________

Street Address:_______________________________ Fax Number:______________

City, State, Zip Code:____

Including records of:

___yes ___no Family History ___yes ___no Mental Health Services
___yes ___no Employment Status ___yes ___no Medical/ Psychiatric treatment
___yes ___no Educational Reports ___yes ___no HIV/ AIDS
___yes ___no Alcohol/Drug Treatment ___yes ___no Other:__________________

I understand records obtained, received, or discussed may contain family history, employment status, educational reports, drug/alcohol treatment, mental health services, medical psychiatric treatment, HIV/AIDS and other pertinent information relevant to treatment services provided.

NOTE: Alcohol/drug and mental health records include all aspects of diagnosis, treatment, and prognosis. By signing this I agree that the agencies and individuals listed above may share and exchange information about my circumstances.

PURPOSE: The information received or exchanged may be used to evaluate my situation and to plan for and coordinate services for me, or for other purposes as listed:_____________________________________.

This permission is good for one year from date of signature.

I understand that I can cancel this at any time, but that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I certify that I understand what this agreement means and that I am signing on my own.

___ Client ___ Parent ___ Guardian ___Legal Power of Attorney

____

Signature Date

____

Kambra J. Meyer, MA, LPC, LCAS Date

This information has been disclosed to you from confidential records protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information without the specific written consent of the person to which it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.