

## **Nicole Taquino, LPC**

### **Consent to Treatment Form**

Nicole Taquino, LPC is committed to providing high quality services to our clients and to providing them with all of the information necessary to be informed about the treatment process. As part of our effort in this regard, we are providing the following information about legal and ethical issues. If you agree to these stipulations, please sign the last page of this form. If you have questions, please discuss them with your therapist before signing the consent.

**1. Confidentiality:** Confidentiality is described as keeping private the information shared between a client and his/her therapist. The following are possible situations that may limit confidentiality: a) Concerns that a client is a danger to himself/herself or someone else; b) The disclosure of abuse neglect, or exploitation of a child, elderly, or disabled person; c) The disclosure of sexual misconduct or unethical behavior of another mental health professional; d) Ordered by the court to disclose information; e) The client directs the release of information; or, f) Otherwise required by law to disclose information. In reference to the treatment of minors, risk-taking behavior that is considered detrimental to the safety of the minor or others will be shared with the minor's parent(s) and/or guardian.

**2. Fees and insurance:** Our standard fee is \$120.00 per 50-minutes session. If you have in network insurance coverage, you are welcome to assign the benefits and pay only your co-pay portion at the time of each visit. **By law we are not allowed to waive deductible or co-payments.** By consenting to treatment, you acknowledge that you are responsible for the cost of these provided services (to you or your minor child) and agree to pay them when billed or at the time of services.

It is important to remember that if you choose to utilize your insurance, we will be obligated to provide them certain information about your case including (but not necessarily limited to) a diagnosis, type and dates of service. By assigning benefits to Nicole Taquino, LPC you are authorizing us to provide your insurance carrier (or their intermediary) whatever information is necessary to process the claim.

**3. Fees for Medical Records:** There is a \$25 fee for each set of paperwork required for the therapist to complete for short term disability, long term disability, or Social Security.

**4. Appointments: If you need to cancel an appointment, 24-hours notice is required. If you miss an appointment without sufficient notification, you will be charged. Missed appointments CANNOT be filed with insurance. Therefore, you are responsible for a \$50 fee.**

**5. Right to withdraw from treatment:** If a conflict arises for the client or the therapist, either has the right to withdraw from the treatment process. If the therapist feels the need to withdraw from providing treatment, he/she will so inform the client and provide appropriate referrals.

**6. Legal Actions:** If legal actions occur in which your therapist is requested to testify or is subpoenaed to provide testimony (such as in a custody or divorce case) you will be responsible to pay the following fees – **regardless if the subpoena is sent from the opposing side of the case or if the case never goes to court.** 1) All travel expenses; 2) A fee of \$250 per hour from the time the therapist leaves the office until he/she returns; 3) A fee of \$250 per hour for the therapist's time preparing for testimony. An initial fee of \$2500 will be required at the onset of the legal action as a deposit for the therapist's services. Any remaining balance will be returned when the case is settled. Record copying fees begin at \$25.00.

**7. Emergency Situations:** In the unlikely event that your therapist in his/her clinical judgment believes you to be dangerous to yourself or to someone else, by signing this consent you authorize him/her to contact either the persons listed as your emergency contacts or someone else to provide assistance through this crisis situation.

**8. The Counseling Process:** The services provided by the staff of Nicole Taquino, LPC are clinical psychotherapy. Therefore, contact with your therapist will only take place in the context of the provision of a professional service. There will be an assessment phase, a treatment phase, and a termination phase to the process. In the assessment phase, the therapist will talk with you to gain historical information and may request that you take

some assessment instruments. He/she will discuss the result of any assessment with you. You will be encouraged to work with your therapist to establish some goals for your work together. In the treatment phase, which will vary in length depending on the issues to be addressed, your therapist will work with you using various methods to help you resolve the issues that brought you to treatment. In the termination phase, therapy will often be concluded by reviewing completion of therapeutic goals.

9. **Risks of Therapy:** At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. It is extremely important and helpful for you to inform your therapist, as soon as possible, of new problems or information that may have a positive or negative impact on your family and/or your child.

10. **After Hours:** In an emergency situation, please call 911. Calls to therapist are returned as soon as possible. However, in the event that your therapist is unavailable, you may also call the Suicide and Crisis Center at any time at 214-828-1000. Non-emergency phone calls will be returned the following business day.

11. **\*\*Electronic Communication\*\*:** It is against HIPAA standards for us to contact you electronically using text or email that is not encrypted. If you so choose to use this means of communication, your therapist will not reveal or respond in any manner regarding counseling PHI (protected health information). Occasionally, we realize urgent matters arise and brief message sent by text or email regarding a scheduling issue may occur. Please understand that information exchanged this way is NOT protected. If you wish for your therapist to respond in an urgent situation, please initial here.

Clients' Initials \_\_\_\_\_

If you approve for your therapist to send weekly appointment reminders via electronic means, please initial here.

Clients' Initials \_\_\_\_\_

If you have read and understand these aspects of consent, please sign below. Feel free to take a copy of the consent if you wish. If you have questions about any of the information on this form, discuss them with your therapist and wait to sign the form with him/her. Insurance questions may be addressed to the office manager. We are looking forward to working with you.

\_\_\_\_\_  
Client or Parent/Guardian Date

\_\_\_\_\_  
Client or Parent/Guardian Date

\_\_\_\_\_  
Child/Teenager Date of Birth of Minor

\_\_\_\_\_  
Therapist Date

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of the Notice of Privacy Practices. \_\_\_\_\_ (Initials)