Heather R. Roberts, MA, LMFT, LPC
Licensed Marriage and Family Therapist
Licensed Professional Counselor
26411 Oak Ridge Drive
The Woodlands, TX 77380
Phone: 281.475.5957
Email: heatherrobertslmft@gmail.com

INFORMATION AND INFORMED CONSENT FOR ADULTS

Date:________________

CLIENT Name: ____
LAST FIRST MI

Age: ________ Birthdate: ____/____/____ Male_____ Female______

Address:
____
STREET CITY STATE ZIP

Phone:
____
HOME WORK CELL OTHER

E-mail address:____

What is the best way to reach you? ____

Who referred you to this office? ____

Do I have your permission to thank the referral source for referring you? Y N

Marital Status: ______ Single ______ Married ________Committed Partnership
________ Separated ________Divorced __________Widow(er)

Spouse/Partner's Name: _______________________________________ Age: _________

On a scale of 1 – 10, how well would you rate your relationship? ____________________

Person to contact in case of emergency: ____

Relationship to Client: _______________ Phone Number(s): _________________________

What is your highest education level achieved?________________________________

Occupation: ____#Years ___________

Employer: ____#Years_________

Previous Employer: ____#Years________

Religion: ______________ Church/Mosque/Synagogue Affiliation: __________________

Are any of the following conditions a problem or struggle for you at this time? Check all that apply.

- □ Anxiety
- □ Anger/Conflict
- □ Stress
- □ Job/School Issues
- □ Marital Issues
- □ Nervousness
- □ Relationship to Parent/child
- □ Self Esteem
- □ Loss of Faith in God
- □ Irrational Fears
- □ Feelings of Guilt
- □ Rage
- □ Family/Relationship Issues
- □ Depression
- □ Sexual Problems
- □ Grief
- □ Lack of Purpose
- □ Loneliness
- □ Loss of Hope
- □ Loss of Meaning in Life
- □ Loss of Work/Job
- □ Substance abuse
- □ Religious Doubts
- □ Thoughts of Harm Self/Others
- □ Self Injury
- □ Blended Families
- □ Other____________

____

____

____

____

What do you consider to be some of your strengths? _______________________________

____

____

What are some areas in your life that you would like to improve? ____________________

____

____

How often do you drink alcohol?

___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never

How often do you engage in recreational drug use?

___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never

Substances used____

MEDICAL/PSYCHOLOGICAL

Name of Psychiatrist: ____________________________ Date of last exam: ___________

Primary Care Physician: __________________________ Date of last exam: __________

Current illnesses and medications:____

____

____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How many times a week do you generally exercise? ______________________________

What types of exercise do you enjoy? ____

Are you currently experiencing any chronic pain? ____ Yes ____ No If yes, please describe: ____

Have you ever received psychotherapy or counseling in the past: (circle) Yes No

When:__________ Name of treating Therapist:__________________________________

PLEASE CAREFULLY READ THE ATTACHED STATEMENT OF POLICIES. THEN READ AND SIGN THE INFORMED CONSENT BELOW. PLEASE KEEP THE STATEMENT OF POLICES FOR YOUR RECORDS.

INFORMED CONSENT

I, _____________________________, (please print name) have read and fully understand the information provided in the Statement of Policies document regarding the various services provided by this office and the potential risks and benefits of outpatient psychotherapy. I also understand the obligations and limitations of confidentiality within the context of the client/therapist relationship. I agree to make payment at the time of service. I agree to cancel appointments only in the event of extreme necessity and I understand that I will be charged $75.00 unless I provide 24 hours advance notice. I understand that I can leave therapy at any time and if I choose to do so will be assisted by the therapist in finding other clinical resources if any are desired.

By signing this document, I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. If I decide to terminate treatment, I will discuss termination before ending treatment.

Before you sign below, please ask any questions you may have of this document. **Your signature acknowledges agreement and understanding:**

____

Print name of Client

____

Client Signature Date

____

Parent/Legal Guardian Signature Date

____

Signature of Therapist Date

COMMUNICATION AND YOUR PRIVACY

Please know that despite security efforts, all electronic communication, including email and cell phone (voice or text) carry an inherent risk of being accessed by unauthorized people, which can compromise your privacy. Even communication about scheduling carries a risk to your confidentiality because it conveys the fact that you are in counseling. Please read and initial the items below to indicate your understanding and consent regarding our communication.

_____1. If I convey sensitive personal information by phone or email/text, Heather R. Roberts, MA, LMFT, LPC can assume that: a) I am making an informed decision accepting the privacy risk, and b) I am comfortable with Heather R. Roberts, MA, LMFT, LPC responding to me by the same communication method, unless I indicate otherwise.

_____2. I consent to using email and text messaging for scheduling and other administrative (nonclinical) purposes.

_____3. I consent to receiving appointment reminder via emails and/or text messaging.

_____4. I consent to receiving email and/or text receipts for credit card payments.

Please sign below indicating your approval to communicating via email and text.

____
Signature of Client Date

____
Signature of Therapist Date

If you are **NOT** comfortable communicating with Heather R. Roberts, MA, LMFT, LPC via email or text, we can do so via phone calls. Please sign below to indicate your preference to **NOT** communicate via email or text messaging.

____
Signature of Client Date

____
Signature of Therapist Date

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STATEMENT OF POLICIES
Please keep this for your records

This sheet may answer any questions that most clients have regarding psychotherapy and my services. Please read it carefully and ask for any clarification before signing the Informed Consent Statement.

The modalities of outpatient psychotherapy utilized in my office are widely accepted forms of psychological treatment. As with all forms of clinical treatment, there are risks to be considered in the process of making an informed decision. This form is designed to inform you of these risks as well as the potential benefits of outpatient therapy, and to discuss the general policies and procedures of my office.

OVERVIEW OF CLINICAL SERVICES

DURATION OF THERAPY: (Initial) ____________
How long a person remains in therapy varies from client to client. The full spectrum is possible: it ranges from "brief" interventions (3-8) sessions to long term therapy (6 months – 3 years). Brief interventions are often crisis oriented with specific, limited goals. Long term therapy often begins with specific limited goals which expand to a larger focus where clients engage in more personal growth work and preventative treatment.

TYPE OF THERAPY: (Initial) ____________
During treatment, I often use a variety of outpatient treatment modalities which include Individual, Family, Couples, and Group psychotherapy.

My treatment approach is based upon each client's specific clinical needs as identified during the initial session(s). The client's therapy options are then discussed and a plan for treatment is determined. A client's needs sometimes change over the course of their outpatient therapy, which may necessitate a reevaluation of their treatment plan. When this occurs, treatment options are once again discussed and determined by the client and therapist. If, at any time, the client and/or therapist believe the client's clinical issues require alternative or additional resources, every effort will be made to assist the client in locating these resources.

While therapy should end through mutual agreement once desired goals have been reached, you have the right to end therapy at any time. Please feel you always have the right to ask questions of me. Therapy only works if you have trust and confidence in me and feel my respect and concern for you.

BENEFITS AND RISKS OF TREATMENT: (Initial) ____________
The risks or potential side effects of participating in psychotherapy may include increased levels of stress and anxiety, relationship disruption, and emotional reactivity as sensitive areas are

explored. Another risk is that psychotherapy may not resolve your problem or concern. I will assess progress on a session-by-session basis. Ongoing lack of progress may be reason for referral.

The benefits of outpatient psychotherapy may include improved functioning in your personal and professional relationships, improved communication skills, and a reduction in the symptoms which led you to seek therapy in the first place.

FEE STRUCTURE AND CANCELLATION POLICY: (Initial) ____________

My fee for individual, couples or family therapy is $150.00 per 55-minute session. Sessions longer than 55 minutes will be prorated based on the per session rate.

- Payment in the form of check, cash, credit card or FSA/HSA card is due at the end of each appointment.

- I **<u>DO</u>** accept insurance plans and will file in-network insurance claims for you. I will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. Please note that you are responsible for immediately notifying me of any changes in your insurance plan. <u>If your insurance carrier fails to make payment for any reason, you will be held responsible for the full payment of fees for services rendered</u>. If you are not using an in-network managed care/PPO/HMO insurance plan and wish to file your own claims, full payment is expected at the time of service; I will provide you with a statement for services rendered.

- Cancellation of an appointment for Individual, Marital, or Family therapy requires <u>24 hours advanced notice</u>. Otherwise, **the client will be charged $75.00 for the missed session**. Emergency circumstances (i.e., hospitalization, accident, a death in the family) will be addressed on an individual basis.

- Fees associated with filling out requested paperwork (i.e. FMLA, disability documentation, letters, etc) are $50.00 per request. Fees associated with writing reports that require extended time (greater than 30 minutes) to complete will be billed at $150.00 per 30-minute increments.

- There will be a $25 charge for all returned checks.

- If fees are not paid within the above terms, the client's account may be turned over to a collection agency.

- If you need to reach me prior to scheduled therapy sessions, you can leave me a message at 281.475.5957. I will return your call as promptly as possible. <u>If at any time, you are unable to get a response and your need is life threatening, please contact your physician, go to the nearest emergency room, or call 911.</u>

ILLNESS POLICY: (Initial) ____________

Therapy is a very effective tool in overcoming stressors and improving important areas of your life. Therapy is the most successful when we are feeling physically well. In order to ensure the safety and health of all individuals in this building, please do not attend therapy when you are ill. Please do not come to the office if you have had a fever in the last 48 hours, have flu-related symptoms, or have excessive coughing. If you are ill and cannot attend your appointment, please notify me as soon as possible. **I may be able to waive the no show/late cancellation fee of $75 under these circumstances**. In addition, I will not see clients if I am not feeling well, have had a fever in the last 48 hours, have had flu-related symptoms, or have had excessive coughing as I do not want to get anyone else sick. If this happens, I will notify you as soon as possible and offer to reschedule you at a later time.

AUDIO OR VIDEO RECORDINGS: (Initial) ____________
At no time are audio or video recordings allowed during sessions, whether in person or via telehealth, without the express, written consent of Heather Roberts. Recording sessions without my knowledge violates the fundamental trust in the therapeutic relationship. If you feel the need to record our sessions, please discuss this with me so that we can come to an understanding as to the purpose of the recordings and how we can navigate any difficulties that may arise.

COURT-RELATED FEES: (Initial) _____________
This therapist will not be hired to be involved in any legal matter whatsoever. I do not perform court consultations or serve as an expert witness in court cases involving child custody, divorce or criminal, civil actions or other matters. If subpoenaed by a court judge, court ordered, or asked to testify, my professional fee is $300 per hour including travel time, preparation for court, consultation with other professionals in preparing for court, and court time. There is a 5-hour minimum charge if I must appear in court. The fees are to be paid in full at least 48 hours before the court appearance. Any additional fees incurred after payment will be due within 48 hours after my court appearance. You also agree to pay a $2.00 per page fee for copies of any records you request, and to pay any associated fees such as notary, postage, etc.

INCAPACITY OR DEATH OF THERAPIST: (Initial) ____________
I understand that, in the event of my death or incapacitation, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature, I hereby consent to another licensed mental health professional, Paula McDonald-Neely LCSW, paulamcdonaldneely@gmail.com to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONFIDENTIALITY:

Please understand that all records, written information, or any electronic data are marked CONFIDENTIAL and are kept under lock and key. No one inside or outside the office will have access to your case except for me. This applies as well to the other therapists in the office. (Initial) _____________

Information shared with a therapist is held in confidence. A signed and dated Release of Information (which clearly defines the nature of information to be shared, to whom and for how long) is required as consent to disclose confidential information. If the client is a minor, the release must be completed, signed, and dated by a parent or legal guardian. (Initial) _________

In counseling children or adolescents, confidentiality is a necessity; as much as possible, for the therapeutic process to work. While you as a parent or guardian have a legal right to information, I will speak with you in a general way unless there is a danger to the child's life. This is conveyed to the child as well. Usually, I ask the child and parent to meet with me together so that the parent can voice concerns or ask questions. (Initial) _____________

COMMUNICATION AND YOUR PRIVACY: (Initial) ____________
Please know that despite security efforts, all electronic communication, including email and cell phone (voice or text) carry an inherent risk of being accessed by unauthorized people, which can compromise your privacy. Even communication about scheduling carries a risk to your confidentiality because it conveys the fact that you are in counseling.

LIMITATIONS TO CONFIDENTIALITY: (Initial) ____________
1. Texas State Law **requires** any therapist to notify the legal authorities if you provide information indicating that you are abusing children, the elderly, or if you express intent to harm yourself or another person(s).
2. If a client reveals to the therapist any evidence of professional misconduct (e.g., sexual involvement) perpetrated by a previous clinical provider, the current therapist is required to report this information to the state licensing board.
3. If your records are court ordered to be released by a judge, I am required by law to release the records to that judge for review.

Failure of the treating therapist to report in circumstances 1 or 2 mentioned above is a breach of legal and ethical standards which can lead to prosecution and/or loss of licensure.

PROBLEM RESOLUTION:

If you have a concern or problem regarding therapy that you and your therapist are unable to work out, you may wish to contact:
Texas Behavioral Health Executive Council
George H.W. Bush State Office Bldg.
1801 Congress Ave., Ste. 7.300 Austin, Texas 78701
Phone: 512-305-7700; 1-800-821-3205, 24-hour, toll-free complaint system
https://www.bhec.texas.gov/discipline-and-complaints/index.html

THIS THERAPIST WILL NOT RETALIATE AGAINST YOU IF YOU FILE A COMPLAINT

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INFORMED CONSENT FOR TELETHERAPY SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of teletherapy (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for teletherapy services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in teletherapy sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, teletherapy is no longer appropriate and that we should resume our sessions in-person.

_______________________________ _______________________________

Client signature Date

_______________________________ _______________________________

Therapist Signature Date