**Client Agreement/Informed Consent**

**Services Offered:**

Counseling services are typically offered as needed, either on a once-per week basis or as determined by the client. Although there are many definitions and philosophies of counseling, the following is a brief description of the philosophy of the services I provide:

*Counseling or psychotherapy is the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a variety of techniques that can be utilized to deal with the problem(s) that brought you to therapy. These services are generally unlike any services you may receive from a physician in that they require your active participation and cooperation. Counseling has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events in your life. Potential benefits include significant reduction in feelings of distress, better relationships, more effective problem-solving and coping skills, and resolutions of specific problems. Given the nature of counseling, it is difficult to predict what exactly will happen, but I will do my best to make sure you will be able to handle and cope with the risks and experience as many of the benefits as possible.*

**Confidentiality:**

Texas state law requires that information provided to mental health practitioners remain confidential, and I make every effort to ensure confidentiality is maintained with respect to all aspects of your treatment. As my client, you agree to the following exceptions to confidentiality, in which case information may be disclosed to the appropriate authorities/agencies/individuals:

* Reason to believe that you may harm yourself or others.
* Reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability.
* Ordered disclosure by state or federal courts.
* Billing your insurance company.

In addition, I require disclosure of information in the following circumstances:

* A signed release form granting permission to designated third parties to receive information (as needed).
* In the case of minors, parents or legal guardians have access to their child’s records, unless emancipated.
* In case of medical emergency, any necessary medical staff will be informed of pertinent health information that I am privileged to.

**Your Rights Regarding Confidentiality:**

* You have the following rights regarding Protected Health Information (PHI) maintained about you. To exercise any of these rights, please submit your request to me in writing.
* Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. One exception to this is the psychotherapy session notes; these notes are confidential and for your therapist’s personal use only. Your right to inspect and copy accessible PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. You may be charged a reasonable fee for copying.
* Right to Amend. If you feel the PHI I have is incorrect or incomplete, you may ask to amend the information although I am not required to agree to the amendment.
* Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that I make of your PHI. You may be charged a reasonable fee if you request more than one accounting in any 12 month period.
* Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket.
* Right to Request Confidential Communication. You have the right to request that I communicate with you about treatment matters in a certain way or at a certain location.
* Breach Notification. If there is a breach of unsecured protected health information concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
* Right to a Copy of this Notice. You have a right to a copy of this notice.

**Weapons Policy:**

I have a strict no weapons of any kind, including handguns, in our offices for the safety and security of all of our clients.

**Email/Text Policy:**

Please consider your confidentiality of information when sending me emails and/or texts. I am not currently equipped with encrypted software and cannot guarantee your privacy in this capacity. In short, do not share information over email/text that you are not comfortable sharing with **everyone!**

**Appointment Scheduling/Attendance/Cancellation:**

I provide services based on the client’s desired frequency of counseling sessions. I expect my clients to be fully engaged in therapy with me and abide by the following procedures regarding appointment times in order to get the full benefits of counseling:

* If you cannot attend a session, please agree to notify me at least 24 hours in advance whenever possible.
* Please understand that you will be charged a full session fee for any session cancelled with less than 24-hours’ notice.
* I reserve the right to transfer/terminate services at any time, for any reason I consider therapeutically appropriate.

*There are policies/procedures in place allowing for exceptions to the above policy. Please discuss any concerns or special circumstances you may have with me. Please note that exceptions to the above attendance policy do not necessarily relieve responsibility for payment of those sessions.*

**Length and number of sessions:**

Counseling sessions typically last 45/60/90 minutes, depending on the individual(s) need(s). They are expected to begin promptly and end at the scheduled time. Although it is understood that there may be instances when you arrive late for a session, late arrival will not extend the scheduled ending time for the session. I am also expected to be on time and will offer appropriate remedy if late, such as making the time up, prorating the fee, etc. The total number of sessions is dependent on a number of factors including your goals, timeframe, rate of progress, etc. It should be noted again that counseling resulting in lasting change is often a long-term process. Please discuss any issues/concerns/questions in regards to length of treatment with me.

**Fee/Payment:**

Fee for service is $120/45-minute session

$140/60-minutes session

$170/90-minute session (ideally for families and couples)

And **must be paid at the time of service.**

* Payment is due at the time of service delivery in the form of cash, check, credit card or insurance.
* You agree to pay a $25.00 service charge for each check that is returned

**Risks of Counseling:**

There are certain risks associated with the counseling process that should be understand before work progresses. These risks are sometimes associated with lack of knowledge regarding the therapeutic process, while most, when experienced, are direct consequences of positive therapeutic movement. Some of the more common risks that you should be aware of are:

* Long-lasting psychological change often requires a significant investment of time, often longer than a client’s initial perception.
* Clients often experience deterioration in emotional and psychological stability at different times during the therapeutic process. This often occurs during the beginning stages of therapy, but may occur at any point, often brought on by an awareness of previously unconscious, emotionally-laden material.
* Relationships are often affected as a result of therapy. Significant relationships will often experience varying degrees of tension. This is often the most prevalent within family relationships, but may extend beyond into one’s social and professional life.

**Therapeutic Relationship:**

The relationship between therapist and client is essential for change to take place. As such, it is often one in which close emotional bonds develop. It is also a professional relationship in which appropriate boundaries must be maintained. For the most part, the therapeutic relationship begins and ends at the therapy office. Although this is sometimes difficult to understand, it is a necessary requirement for maintenance of the therapeutic environment. As such, your therapist cannot be expected to be involved in a social relationship or friendship of any kind that exists outside of the therapy room.

**Grievance/Complaint:**

You have the right to file a confidential grievance if you have any unresolved concerns regarding me or the therapy I have provided. Any grievance should be in written form and addressed to the Texas State Board of Examiners of Professional Counselors.

Complaints Management and Investigative Section   
P.O. Box 141369   
Austin, Texas 78714-1369

1-800-942-5540

**After Hours Policy/Procedure:**

If you need to contact me at any time, you may do so by leaving a message on my confidential voice mailbox. If needed, please discuss other alternative means of contact with me. ***If you are in crisis, please call the 24-hour crisis hotline at (512) 472-HELP or 911.*** I am not a crisis facility and will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs. I may not be available to respond to emergency situations.  ***If you need immediate assistance, please contact the hotline at (512) 472-4357 or 911.***

Client’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Counselor’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_