ROCA Counseling Associates, Inc.

Authorization for Release of Information

I hereby authorize_____
(name of person or organization)

_____
(address) (city) (state) (Zip)

to release all information concerning the evaluation, diagnosis, and/or treatment for

_____
(patient's name)

to_____at_____
(name) (address)

I understand that such disclosure will be for the purpose of evaluation and/or treatment and will be limited to the following specific types of information:

_____History _____Psychological Testing _____ Social History

_____Laboratory Tests _____Physical Examination _____ Discharge Summary

_____Other:_____

_____

_____ _____
(date) (patient's name)

_____
(witness)

1221 [illegible] Road, Suite 232, Box 47 • Richardson, TX 75081 • Office (972) 234-2333 • Fax (972) 234-8964 • email: roca@cowtown.net

ROCA COUNSELING ASSOCIATES, INC.

1221 Abrams Road
Suite 232, Box 47
Richardson, TX 75081
Office (972) 234-2333
www.rocacounseling.com

CONSENT FOR COUNSELING

I, _____ request counseling services from the following counselor and voluntarily consent to such counseling services and administrative procedures as may be performed by this counselor.

☐ Pam Abernethy, M.Ed., L.P.C.

☐ JoDee Hoffman, M.A., L.P.C.

☐ Michaela Temesvary, L.P.C.

I acknowledge that I have received, read, and understand the **PROFFESIONAL DISCLOSURE AND POLICIES STATEMENT** and have been completely informed of the facts relating to this document. All questions concerning this document, counseling methods, and options have been answered to my satisfaction. If I have any further questions, I understand that this counselor will either answer them or find answers for me.

As outlined in the **PROFESSIONAL DISCLOSURE AND POLICIES STATEMENT**.

- I understand there are exceptions to my confidentiality rights
- I understand counseling may not by itself resolve my problems or concerns. I am aware the practice of counseling is not an exact science and so predictions of the effects are not guaranteed. I acknowledge no guarantees have been made to me regarding the results or procedures provided.
- I realize counseling may involve discussing relationships and/or emotional issues that may at times be distressing. I also realize this process is intended to help me personally and with my relationships.
- I acknowledge counseling may make an impact well beyond myself. The results of my work in counseling may affect other individuals close to me, such as family members, marital partners and/or close friends.
- I understand the counselor may make suggestions and/or referrals to outside sources which are intended to be therapeutic, and that I am not required to pursue those recommendations. However, I also understand that in the event I refuse to fail to follow any recommendations given to me by the counselor that I will be held personally responsible for the result.
- ❖ I agree (1) to be contacted by phone and mail using address and phone number I have provided; (2) to pay in full for sessions which I miss with less than a 24 hours' notice; and (3) in the event my account is 30 days past due, to pay for all costs incurred in the collection process.

I understand a signed copy of this **CONSENT FOR COUNSELING** will be part of my case record. I have read, understand, and agree to abide by each and every provision of the **PROFESSIONAL DISCLOSURE AND POLICIES STATEMENT** and this **CONSENT FOR COUNSELING.** I give my consent to receive counseling under the terms and conditions outlined in these documents.

_____ _____

Client Signature Date

_____ _____

Significant Other Signature (if participating in counseling) Date

_____ _____

Counselor Signature Date

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Patient Contact Information

Date: _____

PROVIDER: ☐ Pam Abernethy, M.Ed., L.P.C. ☐ JoDee Hoffman, M.A., L.P.C.

☐ Michaela Temesvary, L.P.C.

Name: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Alternate Number (Description & Number): _____

What is your preferred method of contact?

☐ Cell Phone ☐ Home phone ☐ Alternate Phone ☐ Email

☐ Text (Please provide wireless provider) _____ ☐ Other _____

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REACHING YOUR THERAPIST

REGULAR BUSINESS HOURS
Monday through Friday
Between the hours of 8:00 AM and 5:00 PM
Call (972) 234- 2333

Generally our office staff will be able to take your call during these hours. If we are away from the desk or on another line, you may receive our confidential voicemail. Please feel free to leave a message and we will get back to you as quickly as possible.

AFTER HOURS AND WEEKENDS
Monday through Friday, Between 5:00 PM and 8:00 AM
Weekends, Between Friday at 5:00 PM and Monday at 8:00 AM
Call (972) 234- 2333

After calling our main number, you will be transferred to our confidential answering service. Please feel free to leave a message and we will get back to you as quickly as possible.

EMERGENCIES:

If you are in an emergency situation and need help immediately, please call one of the following numbers:

- ✓ **EMERGENCY 911**
- ✓ **Value Options Mobile Crisis (866) 260-8000 (For Value Options Customers)**
- ✓ **Suicide Crisis Line (214) 828- 1000**
- ✓ **Parkland Psychiatric ER (214) 590- 8761**

If you have any questions, please ask your therapist for clarification of this policy.
Thank you.

_____ _____

Client Signature Date

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NON-COMPLIANCE AND RE-ASSESSMENT SHEET

I, _____ understand that my status as a client will be reassessed if I have three consecutive appointments which I do not keep and which I have not notified my therapist of the cancellation at least twenty-four hours in advance of that appointment. Such no shows can be grounds for termination of client-therapist relationship on the part of my therapist.

I also understand that it is my responsibility to call, twenty-four hours in advance of the appointment, if I need to cancel it. Should you cancel or miss your appointment, and do not notify ROCA Counseling at least twenty-four hours in advance, you will be charged a fee equal to the contracted rate of your insurance company.

I, _____ also understand that the client-therapist relationship can be terminated by the therapist if I am non-compliant in keeping my treatment plan goals, if I show major resistance to my treatment, and I am not willing to take my prescribed medications.

_____ _____
Client Signature Date

_____ _____
Significant Other Signature (if participating in counseling) Date

_____ _____
Counselor Signature Date

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CONFIDENTIALITY & EXCEPTIONS TO CONFIDENTIALITY

Therapy comes with an assumption that what is said by you is kept confidential by your therapist. Certain laws and prudent professional practice affect your therapist's choice to keep your information completely confidential. Please read the following carefully, discuss all concerns and questions with your therapist, and initial as appropriate. The following is not intended to be a guarantee that other circumstances will not arise which may impact confidentiality. You deserve to have exceptions to confidentiality discussed with you, but your legal rights are affected by outside influences, such as changes in the law.

- I, _____, understand that, if I am in imminent danger of harming myself or others:
  - My therapist ***may notify medical or law enforcement personnel*** without my permission.
  - I give my therapist permission to also notify the following person(s):
    Name: _____
    Address: _____
    Telephone: _____
    Relation: _____
  - I understand that my therapist is ***required by law*** to report suspected child or elder abuse (65)
  - I understand that the use of third party payment resources often require reporting by my therapist of otherwise confidential information, such as diagnosis of a mental disorder.

_____ _____

Client Signature Date

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PROVIDER: ☐ Pam Abernethy, M.Ed., L.P.C. ☐ JoDee Hoffman, M.A., L.P.C.

☐ Michaela Temesvary, L.P.C.

RE: Court Action / Legal Fees

Clients are discouraged from having their therapist subpoenaed or having her provide records for the purpose of litigation. Even though you are responsible for the testimony fee, *it does not mean that my testimony will be solely in your favor*. I can only testify to the facts of the case and to my professional opinion. Furthermore, if I see both a husband and wife separately, there is an obvious of conflict of interest. I would rather not damage the trust I have built in the counseling relationship with each client especially if I am still seeing that person for therapy.

If the therapist, Pam Abernethy, M.Ed., L.P.C., is to receive a subpoena, then the attorney or office staff will need to call her office and set up a time for the subpoena to be served during office hours. She will request a minimum of 72 hours' notice of any court appearance so that schedule changes for her clients can be made within a *reasonable* time frame.

Please note: If a subpoena or notice to meet attorney(s) is received without a minimum of 48 hour notice there will be an additional $250 express charge.

Court action fees are as follows:

1. **Preparation time (including submission of records): $220/hr**
2. **Phone calls: $220/hr**
3. **Depositions: $250/hour**
4. **Time required in Giving Testimony: $250/hour**
5. **Mileage: $0.40/mile**
6. **Time away from office due to depositions or testimony: $220/hour**
7. **All attorney fees and costs incurred by the therapist as a result of the legal action.**
8. **Filing a document with the court: $100**
9. **The minimum charge for a court appearance: $1500**

A retainer of $1500 is due 72 business hours before the scheduled court appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt.
If the therapist is subpoenaed and the case is reset with less than 72 business hours' notice prior to the beginning of the day of the subpoena, trial, and/or the testimony is not given, then the client will be charged $500 (in addition to the original retainer of $1500 for having to appear in court).
All fees listed above are doubled if counselor is scheduled to going out of town.

Bills are presented to clients on a weekly basis and payment is expected upon receipt. *If payment is not made within a week of invoice being sent out, your credit card on file will be charged.* A zero balance must be kept at all times.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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PATIENT INFORMATION SHEET

Date: _____

Our staff wants to have the most complete picture possible of you, the client, in order to best understand your situation. We appreciate your cooperation.

PROVIDER: ☐ Pam Abernethy, M.Ed., L.P.C. ☐ JoDee Hoffman, M.A., L.P.C.

☐ Michaela Temesvary, L.P.C.

PERSONAL INFORMATION

1. Name of Client: _____

2. Address: _____

City: _____ State _____ Zip code _____

3. Home Phone: _____ Cell Phone: _____

Email: _____

Alternate Number (Description & Number): _____

What is your preferred method of contact? ☐ Cell Phone ☐ Home phone ☐ Email

☐ Alternate Phone ☐ Text (Please provide wireless provider) _____

☐ Other _____

4. SS No. _____-_____-_____ 5. Date of Birth: _____-_____-_____

6. Age: _____ 7. Sex: ☐ F ☐M

8. Race or Ethnicity: ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic/Latin

☐ Other (Explain): _____

FAMILY INFORMATION

9. Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unmarried

If married, length of time in present marriage: _____ If divorced/widowed/separated, length of time: _____

10. Occupation: _____ 11. Employed by: _____

12. Yearly Income of Family: ☐ Less than $10,000 ☐ $10,000-$15,000 ☐ $15,000-$25,000

☐ $25,000-$35,000 ☐ $35,000-$45,000 ☐ $45,000+

13. List by name the members of your current family in order of their age, beginning with the oldest.

Name	Age	M/F	Current Level of Education

14. Client was raised by: ☐ Both biological parents ☐ Adoptive Parents ☐ Foster family

☐ Mother and Stepfather ☐ Mother only ☐Father and Stepmother ☐ Father only

☐ Other_____

15. List by name the members of the family in which you grew up in order of their ages, beginning with the oldest.

Name	Age	M/F	Current Level of Education

MEDICAL HISTORY

16. Have you ever had problems with any of the following?

☐ Eating (Age at onset of problem :_____) If yes, describe: _____

☐ Sleeping (Age at onset of problem :_____) If yes, describe: _____

☐ Disease (Age at onset of problem :_____) If yes, describe: _____

☐ Serious Injury (Age at onset of problem :_____) If yes, describe: _____

☐ Other (not specified, Age at onset of problem :_____) If yes, describe: _____

17. Have you ever been hospitalized for psychological reasons? ☐ No ☐ Yes

If yes, explain: _____

_____

18. Have you ever been hospitalized for physical reasons? ☐ No ☐ Yes

If yes, explain: _____

19. Name of primary physician: _____

20. Have you ever seen a psychiatrist? ☐ No ☐ Yes

If yes, explain: _____

21. How long since your last complete physical? _____

22. Have you ever taken medication for psychological reasons? ☐ No ☐ Yes

If yes, name & purpose of the medication: _____

23. Are you currently taking medication? ☐ No ☐ Yes

If yes, name & purpose of the medication: _____

24. Have you had a neurological examination? ☐ No ☐ Yes

If yes, results: _____

PURPOSE OF COUNSELING

25. Describe what issue(s) bring you to this counseling session?

_____

_____

_____

26. When were you first aware that you needed help with this issue(s)?

_____

_____

27. How have you attempted to deal with this issue(s) before now?

_____

_____

28. Other agencies or individuals from when whom you have received (or are new receiving) counseling.

Name	Address	Dates
_____	_____	_____
_____	_____	_____

29. _____ (Initial) Due to a recent increase in cancellations without notice, we are regretfully implementing a cancellation fee. Should you cancel or miss your appointment, and do not notify ROCA Counseling at least twenty-four hours in advance, you will be charged a fee equal to the contracted rate of your insurance company.

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ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the ROCA Counseling Associates, Inc.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please be specific):

_____

_____

_____ _____

Employee Signature Date

Witnessed: _____ Date: _____

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PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of your privacy rights and my legal duties and privacy practices with respect to your PHI. I am required to abide by the terms of this notice with respect to your PHI but reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that I maintain. I will provide you with a copy of the revised notice sent by regular mail to the last address you have provided to me for this communication purpose.

Understanding Your Personal Health Information

Each time you visit a hospital, physician, mental health professional or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, in the case of a mental health professional, psychotherapy notes, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the
- outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of my practice, the facility that compiled it, the information belongs to you. You have the following privacy rights:

1. The right to request restrictions on the use and disclosure of your PHI to carry out treatment, payment or health care operations. You should note that I am not required to agree to be bound by any restrictions that you request but am bound by each restriction that I do agree to.
2. In connection with any patient directory, the right to request restrictions on the use and disclosure of your name, location at this treatment facility, description of your condition and your religious affiliation. (I do not maintain a patient directory.)
3. To receive confidential communication of your PHI unless I determine that such disclosure would be harmful to you.
4. To inspect and copy your PHI unless I determine in the exercise of my professional judgment that the access requested is reasonably likely to endanger your life or physical safety (Note: if state law allows, emotional safety, it may be included as well) or that of another person.

   You may request copies of your PHI by providing me with a written request for such copies. I will provide you with copies within ten (10) business days of your request at my office. You will be charged 25¢ for each page copied and you will be expected to pay for the copies at the time you pick them up.
5. To amend your PHI upon your written request to me setting forth your reasons for the requested amendment. I have the right to deny the request if the information is complete or has been created by another entity. I am required to act on your request to amend your PHI within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you. If I deny your requested amendment I will provide you with written notice of my decision and the basis for my decision. You will then have the right to submit a written statement disagreeing with my decision which will be maintained with your PHI. If you do not wish to submit a statement of disagreement you may request that I provide your request for amendment and my denial with any future disclosures of you PHI.
6. Upon request to receive an accounting of disclosures of your PHI made within the past 6 years of your request for an accounting. Disclosures that are exempted from the accounting requirement include the following:
   * Disclosures necessary to carry out treatment, payment and health care operations.
   * Disclosures made to you upon request.
   * Disclosures made pursuant to your authorization.
   * Disclosures made for national security or intelligence purposes.
   * Permitted disclosures to correctional institutions or law enforcement officials.
   * Disclosures that are part of limited data set used for research, public health or health care operations.

   I am required to act on your request for an accounting within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you of the reason for the delay and the date by which I will provide the accounting. You are entitled to one (1) accounting in any twelve (12) month period free of charge. For any subsequent request in a twelve (12) month period you will be charged $.25 for each page copied and you will be expected to pay for the copies at the time you pick them up.
7. To receive a paper copy of this privacy notice even if you agreed to receive a copy electronically.
8. The right to complain to me and to the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe your privacy rights have been violated. You may submit your complaint to me in writing setting out the alleged violation. I am prohibited by law from retaliating against you in any way for filing a complaint with me or HHS.

USES & DISCLOSURES

Your written authorization is required before I can use or disclose my psychotherapy notes which are defined as my notes documenting or analyzing the contents of our conversations during our counseling sessions and that are separated from the rest of your clinical file. Psychotherapy notes include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.

It is my policy to protect the confidentiality of your PHI to the best of my ability and to the extent permitted by law. There are times however, when use or disclosure of your PHI including, psychotherapy notes, is permitted or mandated by law even without your authorization.

Situations where I am not required to obtain your consent or authorization for use or disclosure of your PHI psychotherapy notes) include the following circumstances:

- By myself or my office staff for treatment, payment or health care operations as they relate to you.

  Examples:

  - Information obtained by me will be recorded in your record and used to determine the course of treatment that should work best for you. I will document in your record our work together and when appropriate I will provide a subsequent counselor or healthcare provider with copies of various reports that should assist him or her in treating you once we have terminated our therapeutic relationship.
  - A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
- In the event of an emergency to any treatment provider who provides emergency treatment to you.
- To defend myself in a legal action or other proceeding brought by you against me.
- When required by the Secretary of the Department of Health & Human Services in an investigation to
- Determine my compliance with the privacy rules.
- When required by law in so far as the use or disclosure complies with and is limited to the relevant requirements of such law.

  Examples:

  - To a public health authority or other government authority authorized by law to receive reports of child abuse or neglect.
  - If I reasonably believe an adult individual to be the victim of abuse, neglect or domestic violence to a governmental authority, including a social services agency authorized by law to receive such reports to the extent the disclosure is required by or authorized by law or you agree to the disclosure and I believe in the exercise of my professional judgment disclosure is necessary to prevent serious harm to you or other potential victims. If I make such a report I am obligated to inform you unless I believe informing the adult individual will place the individual at risk of serious injury.
  - In the course of any judicial or administrative proceeding in response to:
  - an order of a court or administrative tribunal so long as only the PHI expressly authorized by such order is disclosed, or
  - a subpoena, discovery request or other lawful process, that is not accompanied by an order of a court or administrative tribunal so long as reasonable efforts are made to give you notice that your PHI has been requested or reasonable efforts are made to secure a qualified protective order, by the person requesting the PHI.
  - Child custody cases and other legal proceedings in which your mental health or condition is in issue are the kinds of suits in which you PHI may be requested.
  - In addition I may use your PHI in connection with a suit to collect fees for my services.
  - In compliance with a court order or court ordered warrant, or a subpoena or summons issued by a judicial officer, a grand jury subpoena or summons, a civil or an authorized investigative demand or similar process authorized by law provided that the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought and de-identified information could not reasonably be used.
  - To a health oversight agency for oversight activities authorized by law as they may relate to me (i.e. audits; civil, criminal or administrative investigations, inspections, licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions.)

- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- To funeral directors consistent with applicable law as necessary to carry out their duties with respect to the decedent.
- To the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- If use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- To a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling a disease, injury or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth, death, and the conduct of public surveillance, public health investigations, and public health interventions.
- To a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such persons as necessary in the conduct of a public health intervention or investigation.
- To a public health authority or other appropriate governmental authority authorized by law to receive reports of child abuse or neglect.
- To a law enforcement official if I believe in good faith that the PHI constitutes evidence of criminal conduct that occurs on my premises.
- Using my best judgment, to a family member, other relative or close personal friend or any other person you identify, I may disclose PHI that is relevant to that person's involvement in your care or payment related to your care.
- To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act and implementing authority.
- To Business Associates under a written agreement requiring Business Associates to protect the information. Business Associates are entities that assist with or conduct activities on my behalf including individuals or organizations that provide legal, accounting, administrative, and similar functions.
- I may contact you with appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

If you have any questions and would like additional information you should bring this to my attention at the first opportunity. I am the designated Privacy Officer for my practice and will be glad to respond to your questions or request for information.

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PROFESSIONAL DISCLOSURE AND POLICIES STATEMENT

CLIENT RESPONSIBILITIES: as a client, you have the responsibilities to the following:

1) Ask for what you want in a direct way and ask questions if you need clarification;
2) Set and keep appointments with us and let us know as soon as possible if you can't keep an appointment to avoid charges;
3) Focus on what you came here to accomplish and work to accomplish your goals;
4) Be honest with me;
5) Provide information regarding previous treatment;
6) Follow through with assignments to which you agree;
7) Keep me informed of your difficulties and progress as we work together;
8) Pay your fees on time and discuss any financial difficulties you may have with me;

Your counselor has a right to terminate treatment if fees are not paid in a timely manner.

OFFICE POLICIES

APPOINTMENT TIMES: counseling sessions begin by appointment time and are fifty minutes in length. Exceptions may be negotiated if warranted by circumstances.

CANCELLATION POLICY: Your session time is reserved for you. If you are unable to be here for your appointment, you are asked to notify our office at (972) 234- 2333 at least twenty-four hours in advance so that someone else may utilize this time. **If you do not notify our office at least twenty-four hours in advance, you will be billed for the missed session.**

FEES: The first session will be billed at the rate of $120.00 and each additional session will be billed at the rate of $100.00. Contracted rates with insurance providers (i.e. EAP's, Medicaid, HMOs, PPOs, and Managed Care Organizations) may vary. We accept cash, checks and credit or debit cards.

Emergencies: If in your opinion your situation requires more immediate attention than your counselor is able to provide, emergency help can be provided by calling one of the following:

- ✓ **EMERGENCY 911**
- ✓ **Value Options Mobile Crisis (866) 260-8000 (For Value Options Customers)**
- ✓ **Suicide Crisis Line (214) 828- 1000**
- ✓ **Parkland Psychiatric ER (214) 590- 8761**

If the emergency is of life threatening proportions, (1) call your physician or "911", or go to the nearest emergency room or hospital of your choice; then (2) call our office to ensure proper arrangements for follow up care.

On occasion, when your counselor is out of town, if you are in need of assistance, please call your psychiatrist or other therapist if they are available to you. If you do not have a psychiatrist or other therapist, your counselor can provide a therapist's name upon request for you.

If you do not state that you have an emergency, your counselor will return your call at their earliest convenience. Usually within twenty-four hours, or the next business day.

The Counseling Process

Counseling, also known as psychotherapy, is a learning process designed to help you better understand yourself and your relationship. While specific goals may vary, generally speaking, counseling is intended to increase the quality of your relationship with yourself and others. This process can also help clarify thoughts and feelings to enable you to make more effective decisions in your life. Additionally, counseling can assist you in accepting your responsibilities and facing personal issues in a direct way. Patience, self-awareness and forgiveness are frequently a part of this process. Most counseling takes time to be effective.

It is not uncommon to have weekly sessions for between six and twenty-four weeks. Under some circumstances, counseling may last several years. While counseling has been demonstrated to be of benefit for many people in a variety of situations, there is no guarantee of a specific result. As with all types of treatment, there are both benefits and risks. Benefits may include a decrease in depressive symptoms, anxiety, loneliness, or anger. Your relationships and communication skills may improve. Your ability to cope with social, family, and work relationship may also improve, as well as offering you more satisfaction in these relationships. You may also better understand yourself, including a clearer understanding of your motives and values, making it easier for you to make decisions. Your presenting problem may be eliminated, or you may develop skills and see other options for dealing with your presenting problem. You may develop helpful techniques that reduce stress and resolve issues which have troubled you for years.

On the other hand, risks may include the experience of uncomfortable levels of feeling and recalling unpleasant aspects of your personal history. Relationships may change and become more conflictual. Despite all of our best efforts, counseling may simply not work out well for you.

Caveat

Confronting personal secrets in counseling frequently leads to relief and personal growth in relationships. However, confronting individual or family secrets about feelings, money, sex, power, violence, infidelity, and misbehavior can be very unsettling. The counseling process may involve emotional experiences which can be upsetting and even hazardous to personal stability, especially if the problems are partially due to repression of feelings and denial, or other personality defenses. Counseling requires thinking and feeling at carious and deeper levels of personal awareness. For some, the experience of examining themselves and their relationships can be very uncomfortable and disturbing, especially to persons whose lives and relationships are rigidly defined. In addition, while some people experience relief early in the counseling process, they may also experience taking two steps back in order to take one step forward.

Moreover, the results of counseling may affect other individuals who are not attending the session. The counseling of families, couples, children and adolescents, will almost always involve important shifts in the entire family.

Discussing emotional issues can be stressful and upsetting. If this occurs in our session, caution should be taken when leaving your counseling session. Your ability to stay focused on any activity including those that can be hazardous, such as driving a car or operating heavy equipment, may be affected. If you experience such emotional distress, it is important to make arrangements to ensure your safety when leaving your counseling session, such as alternative forms of transportation.

The Counseling Relationship

Although our sessions will be very intimate, it is important for you to understand that you have a professional, rather than a personal relationship, with your counselor. Please do not invite your counselor to social gatherings or offer gifts. You will be best served by keeping your relationship strictly professional. You will likely have a variety of feelings about your counselor as you work together. This is a very normal part of the counseling process. Your counselor will be giving you support including feedback and confrontation when they think it could be helpful. You may have intense feelings about your counselor doing this, and it will be important for you to discuss those feelings with your counselor. In the event that you become angry with your counselor or dissatisfied with your work together, it will be important for you to talk to your counselor about it. Frequently, discussions about these kinds of feeling can lead to important insights and significant progress.

Client Rights

As a client, you have the right to the following:

1) Ask questions regarding any aspect of your counseling at any time;
2) Ask questions about issues relevant to the counseling you are receiving, such as the counselor's attitudes or values;
3) Be fully informed of the counselor's qualifications to practice, including training and credentials, years of experience, areas of specialization and limitations;
4) Be fully informed of the limits of confidentiality in the counseling setting, including with whom and under what circumstances the counselor may discuss the case;
5) Be fully informed of the extent of written or taped records of your counseling and their accessibility;
6) Be fully informed of your diagnosis;
7) Be fully informed regarding your counselor's estimation of the approximate length of time required to meet you r agreed upon goals;
8) Be fully informed regarding the format of counseling;
9) Be fully informed regarding the fees for counseling and methods of payment, including insurance reimbursement;
10) Be fully informed regarding the counselor's policies on issues such as missed appointments and emergency coverage;
11) Specify or negotiate counseling goals and to renegotiate these when necessary;
12) Refuse any particular intervention or counseling strategy;
13) Request that the counselor evaluate the progress of therapy;
14) Discuss any aspect of your counseling with others outside of the counseling setting, including consulting with other counselors;
15) Refuse to answer any questions;
16) Terminate therapy at any time.

Consumer complaints regarding ROCA Counseling Associates, Inc. may be reported to the following organization:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3183
(512) 834- 6658