Elizabeth Curl Reep, LCSW

Children, Adolescent, & Adult Counseling
Marriage & Family Therapy
Service Members & Military Families

How did you hear about me?

- Yellow Pages ☐
- Internet Yellow Pages ☐
- My Website ☐
- Psychology Today ☐
- Internet Search ☐
- Insurance Company ☐
- Advertisement ☐
- Drove by ☐
- School_____
- Referred by_____
- Other_____

ELIZABETH CURL REEP, LCSW
CLIENT INFORMATION AND CONSENT

I welcome you! It is my desire to ensure that your participation in counseling will be a most productive and satisfying one. In order to facilitate a therapeutic relationship, I have set forth certain information which will enable you to make an informed consent to counseling.

Therapist
My name is Elizabeth Curl Reep and I am a Licensed Clinical Social Worker. The Texas State Board of Social Work Examiners, 1100 West 49th St., Austin, TX 78756, (512) 719-3521, licenses me to provide mental health services. I am also a member of the National Association of Social Workers. I am in private practice and operate as an independent practitioner.

Mental Health Services
While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you will achieve change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded conceptualizations of your life, relationships, circumstances, and future, 3) move toward resolving your concerns, and 4) forge a plan that promotes greater realization of your human potential, happiness, and success. As your therapist, using my knowledge of human behavior and the human change process, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you or I feel it would be helpful.

Appointments
Persons are seen in the office on an appointment basis. Appointments may be made by calling me at (817) 715-2785 or emailing me at ereep@reepcounseling.com. Appointments are 50-minute sessions.

Number of Visits
The number of sessions needed is variable and depends on many factors, which we can discuss in the session.

Relationship
You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service. In the event that paths cross in social or public settings, the therapeutic relationship comes first. In order to protect your confidentiality, the therapist will not initiate a greeting.

Cancellations
Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged for the missed appointment. You are responsible for calling to cancel or reschedule your appointment. When you make an appointment you are reserving a time. As your therapist, I have agreed not to utilize that time slot for any other purpose. If you fail to keep your appointment and fail to give adequate notice, I am unable to schedule another use for that part of my workday.

Payment for Services:
My standard fee is $125 per session. Payment for services may be made by cash, credit card or personal check. There will be a $25 fee for returned checks.

Insurance and Employee Assistance Programs
TriCare Insurance and Employee Assistance Programs
For clients with TriCare Insurance or Employee Assistance Program coverage with an EAP company with which I am affiliated, I will file your insurance/EAP claims for reimbursement. However, you are responsible for any deductible or co-payment at the time of session. In the event the insurance company fails to reimburse for services, you will be responsible for the entire fee.

Out-Of Network Provider
I operate as an out-of-network provider, for some insurance companies, such as, but not limited to: Blue Cross Blue Shield, Aetna and United Health Care. I am happy to provide all the necessary paperwork to file for insurance reimbursements. Generally speaking, most insurance companies will pay a percentage of each session after you meet your deductible. The majority of my clients' insurance companies reimburse them at a 60/40 or 70/30 percentage split. There are several reasons many successful,

established mental health professionals choose not to join some insurance panels. There is a great deal of paperwork to submit for in-network benefits, making it an impractical use of the clinician's time. The in-network filing process sometimes requires a significant breach of client confidentiality. For example, to meet the requirements for in network reimbursement, the counselor must submit an official client diagnosis and an ongoing progress report, treatment plan, etc. Such information requires that the therapist divulge a good deal of personal information about the client, which then becomes part of his or her permanent medical record. Additionally insurance panels' fee schedules are well below national averages.

Court Related Processes

Although it is my goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. Should you subpoena Elizabeth Curl Reep as a factual witness or involve her in court-related processes, you will be charged a retainer fee of $1500, with a charge of $240 every hour she is involved in case preparation, phone calls, travel, and witness time, etc. Should you issue Elizabeth Curl Reep without her approval (see above), the subpoena will be directly turned over to her attorney and a bill will be rendered to you for immediate retainer fee payment.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health party is an issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to my attention in the beginning of the first session when we discuss this matter further. By signing this information consent form, you are giving your consent for me to share confidential information with all persons mandated by law and with the agency that referred you and the managed health care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also

releasing and holding harmless this therapist from any departure from your right of confidentiality that may result.

Duty to Warn
In the event my therapist reasonably believes that I, the undersigned client, (or my child if child is the client) am in danger, physically or emotionally, to myself or another person, I hereby specifically give consent to my therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:
Name Relationship Telephone Number

_____

_____

I, the undersigned client, consent for my therapist to communicate with me by mail, phone, email and text at the addresses and phone numbers I have provided to the therapist, and I will IMMEDIATELY advise the therapist in the event of any change.

Risks of Therapy
Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of effort you are prepared to give to this endeavor.

Therapist's Incapacity or Death
I, the undersigned client, acknowledge that, in the event my therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my files and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by my therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

Emergency Services
I am unable to provide services 24 hours per day, seven days per week. In the event that you become in need of emergency services when I am unavailable, you may call 9-1-1 or go to the nearest emergency room.

Consent to Treatment
I, the undersigned client, voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I, understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. However, premature termination may result in failure to achieve therapeutic outcomes.

I hereby authorize the release of necessary medical information for insurance purposes. I authorize the payment of medical benefits to the provider of services.

Consent to Treatment of a Minor
We/I, the undersigned _____, parent(s) and/or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

If I am consenting to treatment of a minor child(ren), I hereby attest that I have the right to consent for treatment of the following child(ren)_____
and that if a court order has been entered with respect to the conservatorship/right to consent for treatment of said child(ren), or impacting my rights with respect to consent to the child(ren)'s mental health care and treatment, I will provide a copy of all current and appropriate documents. I understand that services will not be rendered to my child until the therapist has received and reviewed a copy of the most recent applicable court order/appropriate documentation.

By signing this Client Information and Consent Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____	_____
Client	Date
_____	_____
Parent/Guardian	Date
_____	_____
Spouse	Date

As witnessed by:

_____	_____
Elizabeth Curl Reep, LCSW	Date

_____I understand that if my child has parents that are divorced and/or part of a joint custody arrangement, I must furnish Elizabeth Curl Reep with a copy of the custody agreement/divorce decree. (If applicable, please initial)

The therapeutic environment necessary for effective counseling services is disrupted when attorney's, judges and the legal system becomes involved.

____I agree that I will not disrupt the therapeutic environment by involving attorney's, judges or the legal system into the course of counseling for divorce, custody or visitation purposes.

PERSONAL INFORMATION

(Please Print)

Client's Full Legal Name_____
Last, First MI

Parent/Guardian's Name (if Applicable)_____
Last, First MI

Address_____
Street City Zip

Telephone (Cell) _____ (Alternate) _____

*By providing my contact information, I grant Elizabeth Curl Reep to leave a message on your answering machine, voicemail, email or text.

Birth Date_____ Age_____ Sex_____

Married_____ Single_____ Divorced_____ Widowed_____ Cohabitate_____

Spouse _____ Birth Date_____

Education: Years or grades completed_____School:_____

Degree(s) earned: _____

Employer_____How long at present job? _____

Email address_____

Alternate Email address_____

Primary Care Physician_____ Phone_____

List any medication problems or current medications_____

_____

Have you had counseling and/or psychiatric care before? Yes_____ No_____

If yes, when and with whom? _____

IN THE EVENT OF AN EMERGENCY, PLEASE NOTIFY:

Name_____Relationship_____

Phone_____ Alternate_____

CLIENT FEE AGREEMENT & CANCELLATION POLICY

1. Standard fee for service is $125.00 per session.
2. Payment may be made in cash, credit card or personal check at the beginning of each session.
3. As a courtesy, I will provide clients with an invoice with diagnosis and billing codes so that you may submit the invoice to your insurance company for reimbursement once payments have been received.
4. Payment plans are available if prior arrangements have been made.
5. There will be a $25 processing fee on returned checks and denied credit cards. Additionally, following a check return cash, money order or credit card payments will be required for subsequent sessions.
6. Phone calls longer than 10 minutes will be charged at a rate of $40 per half hour.
7. My normal method of payment will be:
   ____Check
   ____Cash
   ____Credit Card

Appointment cancellations must be made within 24 hours prior to scheduled appointments. I understand that if I miss or cancel an appointment with less than 24 hours notice, I will be charged for the session. Any exceptions will be discussed on an individual basis with your therapist.

I have read and understand the client fee agreement. I am responsible for all outstanding balances incurred by me including insurance deductibles and co-payments and unpaid claims. I also understand that payment is due at the time of session unless prior arrangements have been made.

_____ _____

Client Signature Date

Elizabeth Curl Reep, LCSW
Children, Adolescent & Adult Therapy
Marriage & Family Counseling
Service Members & Military Families

Credit Card Authorization Form

I authorize Elizabeth Curl Reep, LCSW/Reep Counseling to process the listed credit card for payment of fees/services.

Type of Credit Card:

Visa MasterCard American Express Discover

Name on Card_____

Number on Card_____

Expiration Date_____/_____

Billing Address:_____

City_____State_____Zip_____

I agree that the above information is true and I understand that my card will be charged and I will be responsible for the fees. I understand that my credit card information will be kept securely on file and charged for fees/services, unless otherwise advised.

_____ _____
Signature Date

_____
Printed Name

TriCare Insurance and EAP Clients

1. Standard fee for service is $125.00 per session.
2. I am currently on the following Insurance and Employee Assistance Program Panels: TriCare, Ceridian/Military One Source/LifeWorks, EAP Consultants, WellPoint, and Anthem.
3. You are responsible for any deductible and co-payment or non-payment at the time of the session.
4. In the case that your insurance company does not cover charges, you will be responsible for unpaid claims.
5. Payment may be made in cash, credit card or personal check.
6. Payment plans are available if prior arrangements have been made.
7. There will be a processing fee on returned checks.
8. My normal method of payment will be:
   ____Cash
   ____Check
   ____Credit Card

Primary Insured_____D.O.B._____

Insurance Company_____Employer_____

Insured ID#_____Group #_____

Insurance Phone #_____

Claims Address_____

_____

_____

I have read and understand the client fee agreement. I am responsible for all outstanding balances incurred by me including insurance deductibles and co-payments and unpaid claims. I also understand that payment is due at the time of session unless prior arrangements have been made.

_____ _____

Client Signature Date

Email & Text Correspondence Disclosure of Protected Health Information

Clients are offered optional email & text correspondence to address general inquiries. The purpose of this option is not to substitute follow-up visits with the Elizabeth Curl Reep, but to serve as an alternate means of communication with your health care provider. In reply to your email you may be instructed to follow up in our office to address your questions or concerns.

I understand that email & text correspondence is an alternate form of communication with Elizabeth Curl Reep and is not to be used for emergencies. I understand that responses to my email & text inquiries will be addressed as time permits and are not meant for "time sensitive" issues.

The contents of Ms. Reep's corresponding emails & texts may include your personal health information. I hereby grant Elizabeth Curl Reep permission to communicate with me via my email & text platforms. Elizabeth Curl Reep will **not** be held responsible for any individual who gains access to the contents of the corresponding emails & texts regardless of the means by which it occurred.

I, _____, agree to participate in the email & text correspondence option. I certify that I have read and understand the above information. If I decide to change my decision to participate in this option I agree to do so by notifying Ms. Reep in writing.

_____ _____

Signature Date

_____

Printed Name