

This form provides you with information that is in addition to that detailed in the Notice of Privacy Practices.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of client) hereby attest and I have voluntarily entered into treatment or give my consent for the minor or person under my legal guardianship mentioned above, at Anchor to Serenity LLC, hereby referred to as the center. Further I consent to have the treatment provided by a counselor, or intern with collaboration with his or her supervisor. The rights, risks, and benefits associated with treatment have been explained to me. The clinic encourages that this decision be discussed with the treating counselor. This will help me facilitate more appropriate plan for discharge.

***Please initial each line at the end of each section to ensure your understanding.***

1. **Counseling** is a collaborative process between you and a counselor to work on areas of dissatisfaction in your life and assist you with life goals. For counseling to be most effective, it is important that you take an active role in the process. Counseling activities are governed by the Texas State Board of Examiners for Professional Counselors for LPC’s. \_\_\_\_\_\_\_\_\_\_(Initial)

**I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress. I do not provide custody evaluation recommendation, nor medication or prescription recommendation, nor legal advice, as these activities do not fall within my scope of practice.**

2. **Time Parameters**: Individual appointments are scheduled for 45-minute segments. Being late for an appointment by 15 minutes or more may require that you reschedule as available. You will be charged a missed appointment fee should this occur. \_\_\_\_\_\_\_\_\_\_(Initial)

3. **Confidentiality**: As a Licensed Professional Counselor in the State of Texas, I am bound by the Texas Administrative Code, Chapter 681 and the Health and Safety Code, Chapter 611. In accordance with these rules, information obtained in the counseling session or in written form will not be disclosed to any outside person(s) or agency without your written permission except when such disclosure is necessary to “protect you or someone else from imminent harm” or is otherwise legally required and/or allowed by law, such as abuse or neglect of a child under 18, elder, or disabled person. This notification may include notifying the victim, notifying the police, or seeking appropriate hospitalization. I may also be required to provide information to the court if provided a court order. If a client files a worker’s compensation claim or disability claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought. If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties. *If I run into you outside of the counseling office, I will protect your confidentiality and wait for you to acknowledge me should you choose to do so*. \_\_\_\_\_\_\_\_\_\_(Initial)

4. **Risks**: In counseling, major life decisions are sometimes made, including decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of the counseling experience as a result of an individual’s calling into question many of their beliefs and values. Furthermore, symptoms may be intensified, and the emotional experience may be too intense to deal with at this time. I will be available to discuss any of your assumptions or possible negative side effects in our work together. There is no guarantee of what you will experience in counseling. \_\_\_\_\_\_\_\_\_\_(Initial)

5. **Cancellation**: If you find it necessary to cancel an appointment, please contact me at 512-429-4334 at least 48 business hours in advance. Cancellations with less than 24 hours advance notice will be charged a $75 no-show fee. This provider may also terminate counseling in the event the client has missed 3 appointments without calling to cancel 24 hours prior to the scheduled appointment. \_\_\_\_\_\_\_\_\_\_(Initial)

 6. **Emergencies**: If an emergency for which you feel immediate attention is necessary, please contact emergency services (911) immediately, or go to your nearest hospital emergency room. I will follow those emergency services with standard counseling and am available to be texted at 512-429-8206 – please indicate when a call is urgent as calls are returned during normal business hours. Keep in mind that while I may be in the office, I do not answer the phone while in session with a client.

If I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can, within the limits of the law, to prevent you from injuring yourself others and to ensure that you receive the proper medical care. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of injury to self or others. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary. **Please do not use e-mail and faxes for emergencies**. \_\_\_\_\_\_\_\_\_\_(Initial)

7. **Fees and Payment** will be collected at the time of service; cash, check, Visa, or MC are acceptable forms of payment. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc… will be charged at the standard rate in the payment contract for services, unless indicated and agreed upon otherwise. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. If requested, I will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. You must be aware that not all issues/problems dealt with in counseling are reimbursed by insurance companies and filing may require the release of confidential information such as mental health diagnosis, which could be utilized in future insurance decisions. It is your responsibility to verify the specifics of your coverage and determine if pre-authorization is required. \_\_\_\_\_\_\_\_\_\_(Initial)

8. **Health Insurance & Confidentiality of Records**: If you want your EAP or insurance to pay for part of your treatment, I must be able to discuss your diagnosis and treatment with their representative if they contact me for additional information. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk of confidentiality or privacy. \_\_\_\_\_\_\_\_\_\_(Initial)

9. **Consultation, Supervision**: Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service. \_\_\_\_\_\_\_\_\_\_(Initial)

10. **Electronic Transmission**: I cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any email sent to me via a computer in a work-place environment is legally accessible by others in this office. I do not always check email daily. \_\_\_\_\_\_\_\_\_\_(Initial)

11. **Records**: I am required by law to maintain records of each time we meet or talk on the phone. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply. I can be called to testify about the contents of the records, and I must comply. Also, in order to file for insurance reimbursement, I have to assign you a diagnosis. If you have any questions about this, please let me know. I will certainly share any information with you that I provide to an insurance provider. If records are requested for any purpose, my policy is to provide an appropriate summary as records can be misinterpreted. \_\_\_\_\_\_\_\_\_\_(Initial)

12. **Litigation Limitation**: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to the many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc…), neither you (client’s) nor your attorney’s, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. If you do become involved in litigation requiring your therapist’s participation, you will be expected to pay for the professional time even if your therapist is compelled to testify by another party. \_\_\_\_\_\_\_\_\_\_(Initial)

13. **Termination**: If at any time you want another professional’s opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if I have your written consent, will provide him or her with the essential information needed. You have the right to terminate therapy at any time. \_\_\_\_\_\_\_\_\_\_(Initial)

 I have read, understood, agree, and consent to the above conditions of service stated. I have also received the notice of privacy practices on this date and have had the opportunity to ask questions about and understand these policies.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

**(\*\*For Minors Only)**

I hereby grant permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to counsel my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please return this back to the receptionist. This will be kept in your personal file for 7 years.***

***If you would like a copy, the reception will gladly make you one.***