Ronald D. Davenport, M.Ed.
**Licensed Professional Counselor**
**800 Rockmead, Suite 161**
**Kingwood, Texas 77339**
Telephone 281-359-3283 ✦ Fax 281-913-1850 ✦Website RonDavenportCounseling.com

## COUNSELING AND PRACTICE INFORMATION

Please read the back and front of this page. It contains important information about my practice and the practice of counseling and psychotherapy in general, as well as information from the state about "What to Expect From Your Licensed Professional Counselor." If you should ever have any questions, please, always ask. I look forward to a productive therapeutic relationship with you.

## APPOINTMENTS AND OFFICE SCHEDULE

Office hours are Monday through Thursday 9:00 A.M. to 7:00 P.M. and Friday 10:00 A.M. to 2: 00 P.M. Sessions are 45 to 50 minutes in length. As a Client you will be assigned a time slot that is yours while you are working with me. These times will usually be either weekly or bi-weekly. Because this time is set aside for you, it is your responsibility to attend your sessions as agreed.

## FEE SCHEDULE

**INITIAL SESSION - $150** (individual, marital or family therapy session, regardless of the number of persons participating)
**REGULAR SESSION - $120.00**
**EXTENDED SESSIONS AND TELEPHONIC CONFERENCES- $60.00 for each 25 minute period or portion thereof** (The regular therapy session is 45 minutes in length.)
**INSURANCE -** If you are a member of one of the insurance companies for which I am a provider, you will be charged at their contracted rate.
**INSURANCE FILING:** I will only file for those insurance companies for whom I am a provider.
**INSURANCE COPAYS/DEDUCTIBLES:** You are responsible for all copays and deductibles. Those fees are due and expected at the time services are rendered.
**FEE PAYMENT:** I do not accept checks. Cash is preferred and most credit cards are accepted.

**IF YOU MISS AN APPOINTMENT OR DO NOT CANCEL AN APPOINTMENT 24 HOURS IN ADVANCE, YOU, OR THE RESPONSIBLE PARTY, WILL BE CHARGED FOR THE SESSION AT THE FULL INSURANCE CONTRACTED RATE OR THE FULL REGULAR SESSION RATE BASED ON YOUR CURRENT STATUS. INSURANCE COMPANIES WILL NOT PAY FOR MISSED SESSIONS. IF YOU DO NOT SHOW OR FAIL TO CANCEL YOUR APPOINTMENT TWO TIMES IN A ROW, YOUR TIME SLOT WILL BE CANCELLED.**

**PREPARATION OF DOCUMENTS - $120 per hour with a minimum fee of $60** for time needed to review and prepare the document(s) such as reports and letters.
**COURT APPEARANCES OR OTHER LEGAL TESTIMONY-** $300 per hour, including any waiting and travel time. If travel is required, the client is responsible to pay for those expenses ***before*** the travel will be initiated.

## CONFIDENTIALITY

Information provided by you in this counseling/psychotherapy relationship is strictly ***confidential*** and will not be divulged except:

1. Information about child physical or sexual abuse must be reported to proper authorities as required by Texas law.
2. Information indicating an eminent physical threat of violence to yourself or another person which will be resolved and may include reporting to appropriate authorities.
3. When you provide written authorization allowing disclosure.
4. Certain Court Orders can require disclosure of some information.
5. Sometimes consultation with another therapist may be necessary. When this occurs, your identity and confidentiality will be protected.

I value you and your right to confidentiality. Therefore if I see you in places other than the office, I will not initiate contact with you. However, if you initiate contact with me in those situations, I will respond to you, as best I can to protect your confidentiality. You should be aware that many people in the community know my profession and contact by you might risk your confidentiality.

## THERAPEUTIC APPROACHES

Several different types of therapeutic methods are used in providing psychotherapy. These may include: biblio therapy (use of books or other literature), referral for support group involvement, Eye Movement Desensitization and Reprocessing (EMDR), group therapy, or other forms of psychotherapeutic intervention. These will be explained to you, including how they are to help you, so that you can make an informed decision about your therapy. If you ever have any questions about these issues, please discuss this with the therapist.

## INFORMATION ABOUT COUNSELING/PSYCHOTHERAPY

Counseling/Psychotherapy is a dynamic interactive human process. To be effective it requires the vigorous participation of both the therapist and the client.

The therapist views the client as an individual human being with unique strengths, values, perceptions and concepts. The therapist also views the client as the sole person capable to make any changes the client desires. The client is therefore responsible for all the successes in personal changes made.

Success of the therapy is directly related to clearly identifying the thoughts, beliefs, emotions, behaviors, habits, etc. which the client wishes to change. The client's motivation, dedication and desire to change are the greatest indicators of potential success in changing. Client participation involves being attentive to the therapist; providing honest, truthful information; and making honest effort to achieve goals and assignments mutually agreed upon in the sessions as advantageous to the client.

The following information on the back is from the Texas State Board of Examiners of Professional Counselors and explains what you can expect from your licensed professional counselor.

# WHAT TO EXPECT FROM YOUR LICENSED PROFESSIONAL COUNSELOR

**LICENSED PROFESSIONAL COUNSELORS (LPCS)** are regulated by the Texas State Board of Examiners of Professional Counselors, a state board whose members are appointed by the Texas Governor to carry out the general oversight of professional counselors in Texas. LPCs provide counseling services in accordance with state law and the board's rules. This includes following the code of ethics that the board has established for the counseling profession. This brochure is intended to inform you of the ethical conduct that you may expect from your professional counselor.

**YOUR COUNSELING IS FOR YOU.** Everything about the process should focus on enhancing your personal growth and your ability to cope with life's problems. You may expect to be treated with dignity in a professional manner. When you invest yourself in the counseling process, you can experience the satisfaction of working successfully at some of the most important issues in your life. The guidelines established by the board are aimed at promoting a positive counseling experience.

**VALID LICENSE.** You may visit the board's web page and view a roster of counselors to determine if a counselor is currently licensed. The web page also contains information about disciplinary actions taken against counselors. The roster is updated at least every two weeks; however, if a person's name does not appear on the roster, you should call the board office. Since licenses must be renewed annually, and every month a certain number of licenses expire, it is possible that your counselor's name may not appear on a roster that is posted while your counselor is in the process of license renewal.

**TRUTHFUL ADVERTISING.** An LPC is required to be truthful when advertising counseling services to the public. You should receive accurate information regarding your counselor's training and credentials, as well as the scope of what may be accomplished in counseling.

**PRACTICING WITHIN THE SCOPE OF THE COUNSELING PROFESSION.** Your LPC has been trained to provide counseling services. This means assisting you through a therapeutic relationship, using a combination of mental health and human development principles and techniques, including the use of psychotherapy, to achieve your mental, emotional, physical, social, educational, spiritual, or career-related development and adjustment. An LPC may prevent, assess, evaluate, and treat mental, emotional, or behavioral disorders and distresses that interfere with mental health. An LPC may also implement and evaluate treatment plans using interventions that include counseling, assessment, consulting, and referral. You may have occasion to ask questions that require legal, medical, or other specialized knowledge. If so, you should ask your attorney or primary care physician or ask your counselor for a referral to a specialist in your area of concern.

**INFORMATION AT INITIAL SESSION.** At or before your first counseling session, you and your counselor should discuss general information relating to your counseling relationship, such as:

1. Fees for counseling, and scheduling, cancellation and payment policies
2. Goals that will guide the counseling process and methods or techniques that will be used during counseling
3. Any restrictions under which your LPC may be practicing (for example, whether or not the LPC is under the supervision of another mental health professional)
4. Confidentiality aspects of counseling and the circumstances under which something you say would not remain confidential
5. Other persons that may be involved in the counseling process (for example, a team approach in the counseling office or the involvement of a local minister)

**ACCURATE RECORD KEEPING AND BILLING.** Your LPC is required to keep records of your counseling sessions for a period of seven years, or seven years beyond the age of eighteen in the case of a child. These records include dates of treatment, case notes, correspondence, progress reports, and billing information. Billing to you or your insurance company must be only for services rendered according to your agreement with your counselor. You cannot be billed for appointments that never existed, although you may be billed for appointments that were not cancelled in accordance with your counselor's cancellation policy. If you are the parent or guardian of a minor who is in counseling, you are entitled to a written summary and explanation of charges.

**CONFIDENTIALITY.** Everything you discuss with your counselor remains confidential, with only a few exceptions. You must give signed permission before your LPC can share information with anyone about any aspect of your counseling. If you do give permission, you will have an opportunity to specify who should receive information from your file, what information they are allowed to receive, the purpose for which they may use the information, and the period of time during which you are granting permission. Be sure to read carefully any "Release of Information" or "Consent" form you may be asked to sign. If you have questions about the form, ask. The common situations requiring a release of information include certain inquiries from insurance companies, a new counselor wanting to use records from a previous counselor to provide continuing care, and collaboration with another agency or professional in your treatment.

Sometimes, certain situations override your confidentiality. For example, if you are involved in a criminal case, the judge can order your file to be turned over to the court. If you make statements that a child or an elderly or disabled person has been abused or neglected, your counselor is required by law to report that information to the appropriate authorities. If you make statements that indicate you intend to harm yourself or others, your LPC may report that information to medical personnel or law enforcement. There are other similar situations that your counselor should discuss with you before or during your initial session.

Apart from these rare circumstances, however, you can be assured that the only people who will have access to your records or statements are those for whom you have given written consent. This privacy gives you the freedom to speak openly and honestly about your thoughts and feelings.

Parents have a right to receive progress reports on their child's counseling. However, personal information shared by a child during an individual session will be kept confidential unless it involves imminent danger to the child or someone else. Young people will not confide in a counselor if they believe that personal information will be revealed to their parents.

You have a right to a copy of your own Counseling records. This right is guaranteed under state law (Texas Health and Safety Code, Chapter 611.) You may be charged a reasonable fee for a copy of your records. Certain portions of your record may be withheld from you for a period of time for specific reasons as described in the law. You may read the text of this law through a link at the board's web site.

**NO SEXUAL ACTIVITY.** Counseling, by its very nature, often deals with the most private aspects of your life. It is your counselor's responsibility to ensure an atmosphere of safety for you, free from any kind of exploitation. The board does not tolerate sexual misconduct by professional counselors. An LPC is prohibited from engaging in sexual contact, Sexual exploitation, or therapeutic deception with a client or a former client. Such misconduct constitutes grounds for revoking a counselor's license.

**MAINTAINING A PROFESSIONAL RELATIONSHIP.** Your relationship with your counselor should be strictly professional in nature. For example, an LPC is not allowed to invite you into a business venture, barter with you for counseling services, ask you for personal favors, or subcontract with you to do office work. These examples are called *dual relationships* and are unethical.

If you seek counseling with a personal friend, or someone with whom you already have a business or other type of relationship, the LPC must refer you to another mental health professional. Your LPC may not engage in any working or personal relationship with you without informing you that future counseling will no longer be a possibility.

**MORE INFORMATION.** Visit the board's website for more information about licensed professional counselors. From this site, you may view or print the state laws and board rules that govern the provision of Counseling services in Texas.

**A FINAL WORD.** Much of the success of your counseling experience depends on you. You are most likely to reap benefits from counseling if you are motivated, honest, and willing to work at self improvement and self-awareness.

If you have a complaint or concern, speak first to your counselor. If you are unable to resolve the problem, you can file a complaint with the board. You may call our toll-free complaint hotline at (800) 942-5540 or contact us in writing or by e-mail at the addresses shown below.

This brochure is for general informational purposes and does not constitute a legal agreement between any person and the Texas State Board of Examiners of Professional Counselors. All of the information provided is believed to be accurate and reliable; however, the board assumes no responsibility for any errors.

Texas Department of Health
Texas State Board of Examiners of
Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3199
(512) 834-6658
(512) 834-6789 fax
lpc@tdh.state.tx.us
www.tdh.state.tx.us/hcqs/plc/lpc.htm

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Board Certified Professional Counelor

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# PERSONAL INFORMATION & TREATMENT CONTRACT
## PERSONAL INFORMATION

DATE: _____

NAME: _____ SEX: MALE ☐ FEMALE ☐

SOCIAL SECURITY NUMBER: _____ DOB: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

OCCUPATION: _____ EMPLOYER: _____ # YEARS : _____

CONTACT #S

HOME: _____ CELL: _____ WORK: _____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐

NAME OF CURRENT SPOUSE ☐/ PARTNER ☐ _____

RELIGIOUS PREFERENCE: _____

EDUCATION LEVEL: SOME HIGH SCHOOL ☐ HIGH SCHOOL DIPLOMA/GED ☐

SOME COLLEGE ☐ COLLEGE GRADUATE ☐ DEGREE/AREA _____

SOME POST GRADUATE ☐ GRADUATE DEGREE ☐ AREA OF STUDY: _____

HAVE YOU HAD PRIOR PSYCHOTHERAPY? NO ☐ YES ☐ WHEN _____ HOW LONG? _____

PREVIOUS THERAPIST: _____

WHAT BRINGS YOU TO THERAPY AT THIS TIME? _____

_____

WHAT WOULD YOU LIKE TO ACCOMPLISH IN THIS THERAPY? _____

_____

### PERMISSION TO USE TECHNOLOGY IN PROVIDING TREATMENT

I understand that it may be necessary to use many technological means to respond to my requests for contact or information. I understand and agree that Mr. Davenport will attempt to protect my confidentiality and the confidentiality of all information whenever he is responding to a request from me or is attempting to reach me. I give my permission to Mr. Davenport to use the following methods in responding to a request by me during the course of my treatment with him.
**INITIAL IN THE YELLOW BOX** of each of the methods by which Mr. Davenport may contact you and provide the information necessary:

| | | |
|---|---|---|
| Facsimile machines: | | Facsimile number: _____ |
| Computer e-mail: | | Email address: _____ |
| Answering machine: | | Answering machine #: _____ |
| Cellular phone: | | Cell Number: _____ |
| Messages with: _____ | Relationship: _____ | Initials: |

I have received the notifications "COUNSELING AND PRACTICE INFORMATION" and "What to Expect from your Licensed Professional Counselor" and have read, understand and agree with all of the information contained thereon and hereby voluntarily consent to evaluation, recommendation and/or treatment by Ronald D. Davenport, M.Ed., LPC. I understand that the practice of psychotherapy is not an exact science and acknowledge that no guarantee has been made, or implied to me concerning the results of my treatment. I also understand that psychotherapy at times requires discussion of personal events, thoughts and emotions that may be discomforting and my success will depend upon my honest and direct involvement in the therapeutic process.

_____ _____
CLIENT'S (PARENT'S IF CLIENT IS A MINOR) SIGNATURE DATE

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# MEDICAL INFORMATION
# and
# RELEASE FORM
## PRIMARY CARE PHYSICIAN (PCP)/PSYCHIATRIST INFORMATION

CLIENT'S NAME _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN OR PSYCHIATRIST? NO ☐ YES ☐ IF YES

YOUR PHYSICIAN'S NAME _____

ADDRESS _____, CITY _____, STATE ____ ZIP _____

PHONE: _____ FAX _____

TREATMENTS, MEDICAL PROBLEMS, ISSUES _____

_____

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL AND VITAMIN SUPPLEMENTS

☐ NO ☐ YES

IF YES LIST MEDICATIONS/SUPPLEMENTS WITH THE DOSES, IF KNOWN:

_____

_____

_____

_____

**IF YOU ARE UNDER THE CARE OF ANY PHYSICIAN CONCERNING EMOTIONAL/PSYCHOLOGICAL PROBLEMS AND/OR ARE TAKING MEDICATION FOR THESE ISSUES IT IS IMPORTANT THAT THE PHYSICIAN AND THE THERAPIST CONSULT TO INSURE APPROPRIATE COORDINATION OF TREATMENT. BY SIGNING HERE YOU GIVE YOUR PERMISSION FOR ME TO DISCUSS AND COORDINATE YOUR TREATMENT WITH YOUR PCP OR PSYCHIATRIST:**

_____ _____
CLIENT'S (PARENT'S IF CLIENT IS A MINOR) SIGNATURE DATE

**IF YOU DO NOT WISH TO GIVE YOUR CONSENT TO ALLOW COORDINATION WITH YOUR PHYSICIAN YOU MUST CHECK THE BOX BELOW AND SIGN AND DATE HERE.**

☐ I CHOOSE NOT TO HAVE YOU COORDINATE AND DISCUSS MY TREATMENT WITH MY PHYSICIAN AT THIS TIME.

_____ _____
CLIENT'S (PARENT'S IF CLIENT IS A MINOR) SIGNATURE DATE

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# INSURANCE INFORMATION FORM

CLIENT'S NAME _____ DATE OF BIRTH ___ _____ SSN _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

## MENTAL HEALTH (INSURANCE) COVERAGE

_____ INSURANCE COMPANY NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

_____ POLICY/GROUP NUMBER _____ CONTACT NUMBER _____ AUTHORIZATION NUMBER(IF KNOWN) _____ COPAY AMOUNT

## INSURED/SUBSCRIBER INFORMATION (PERSON UNDER WHOSE NAME THE INSURANCE IS CARRIED)

_____ subscriber's name _____ ssn _____ insurance identification number _____ date of birth SEX: MALE ☐ FEMALE ☐

_____ address, if different from client's _____ telephone number _____ employer's name

**********

## IS THERE A SECONDARY HEALTH INSURANCE PLAN? NO ☐ YES ☐ IF YES, COMPLETE THE FOLLOWING:

_____ INSURANCE COMPANY NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

_____ POLICY/GROUP NUMBER _____ CONTACT NUMBER _____ AUTHORIZATION NUMBER(IF KNOWN) _____ COPAY AMOUNT

## SECONDARY INSURED/SUBSCRIBER INFORMATION (PERSON UNDER WHOSE NAME THE INSURANCE IS CARRIED)

_____ SUBSCRIBER'S NAME _____ SSN _____ INSURANCE IDENTIFICATION NUMBER _____ DATE OF BIRTH SEX: MALE ☐ FEMALE ☐

_____ ADDRESS, IF DIFFERENT FROM CLIENT'S _____ TELEPHONE NUMBER _____ EMPLOYER'S NAME

## EMPLOYEE ASSISTANCE PROGRAM COVERAGE (IF BEING USED)

_____ NAME OF EAP COMPANY _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

_____ AUTHORIZATION NUMBER _____ CONTACT NUMBER _____ NUMBER OF SESSIONS

## AUTHORIZATION TO ASSIGN BENEFITS AND RELEASE INFORMATION FOR INSURANCE CLAIMS

I, _____,
(PRINT **CLIENT'S** FULL NAME)

hereby authorize payment of medical benefits to Ronald D. Davenport, M.Ed., LPC; and authorize him to release any information acquired in the course of my treatment, during an evaluation or consultation; or to obtain any information in order to satisfy insurance claims or to determine the status of an insurance claim. I hereby absolve Ronald D. Davenport, M.Ed., LPC of any and all liability resulting from such action. I agree that a photocopy of this permission to release or obtain information is as valid as the original.

_____
CLIENT'S (PARENT'S IF CLIENT IS A MINOR) SIGNATURE

_____
DATE

**FOR OFFICE USE ONLY-DO NOT WRITE IN THIS BOX**
**INSURANCE VERIFICATION**

CONTACT PERSON _____ DATE _____

COPAY _____ # SESSIONS/YEAR _____

# AUTHORIZED _____ AUTHORIZATION # _____

AUTHORIZATION DATES _____ TO _____

MISC INFO _____

_____