

CONSENT FOR SERVICES

Client Name: _____

Date: _____

Parents/Guardians (for minor client): _____

Psychotherapy Services: Participation in therapy includes both risks and benefits, including the risk that symptoms or distress may increase during treatment. Benefits can include decreased emotional distress, greater insight and awareness, more adaptive coping skills and behaviors, and improved communication and interpersonal relationships. Therapy cannot be guaranteed and effectiveness of treatment depends on a variety of factors, including the client's level of participation and effort. The client should be aware that they have options for treatment, including no treatment at all. Attending therapy is voluntary, and client may end treatment at any time. If the client decides that they would like to seek another provider for therapy, I will provide referrals to other providers.

Length of Treatment: Length of treatment will be determined by therapist and client together and will vary based on the client's needs and severity of symptoms. If you are using health insurance to pay for services, please be advised that your insurance provider may have limits on the number of sessions that will be covered. If for any reason I feel that it is necessary or advisable to end treatment before you would like to, I will provide you with appropriate alternative referrals.

Fees: All sessions are 45-55 minutes. Payment is due and payable at the time of service. I accept cash, check, or credit card for payment. Returned checks will incur a \$15 fee. For additional services, such as documentation, attending meetings, providing consultation, or phone calls longer than 15 minutes, I may charge a pro-rated amount, based on our standard session fee. In cases of failure to pay fees, I may enlist the services of a collection agency to collect outstanding debt if necessary. Fees may increase at a future date, and you will be notified in advance if fees are raised. In-network insurance will be billed directly. For out-of-network insurance, you may request a statement to seek reimbursement.

Standard session rate is **\$100**. Copay/reduced rate (if applicable): \$_____

Parental Involvement for Minor Clients: When a minor is the client, parents may be requested to participate in treatment through family sessions or parenting sessions. **A parent/guardian is required to remain on-site during all individual sessions of a minor client.** Parents have a legal right to request information and records about their child's treatment; however, privacy allows children and adolescents to better benefit from the therapy process as they can more openly express themselves. **By consenting to services with me, you are agreeing that I may hold your child's therapy disclosures confidential.** I will inform parents of any significant safety concerns that the minor may disclose.

Cancellation Notice: All cancellations of appointments should be made at least 24 hours in advance. If appointments are cancelled in advance there is no fee for the cancelled session. Cancellations may be left on my voicemail at (512) 660-7279. **An administrative fee of \$25.00 will be charged if you give less than 24-hour notice or no-show for a scheduled appointment. This fee is not covered by any insurance companies.**

If you cancel or no-show for two consecutive sessions or stop attending therapy for two weeks without prior arrangement, your reserved appointment time may be released.

Court: I do not testify in court as a witness and do not provide court testimony for marital or custody disputes. If I am required to testify in civil court, due to court order or subpoena, I will require payment in advance of my standard fee of \$125.00 per hour during the entire time at the court or at the depositions, including travel time.

Confidentiality: Information that you discuss with your therapist is usually confidential and will not be discussed with anyone not covered under the HIPAA regulations (see Notice of Privacy Policy). This means that under most circumstances what is told in a therapy session will not be reported to anyone, even to other family members (except for

therapeutic purposes, in case of a minor). If you wish for information to be disclosed, you may sign a request to release information. There are limits to confidentiality under any of the following circumstances:

1. If you are a serious danger to yourself
2. If you threaten serious harm to others
3. If I have reasonable suspicion or am told of abuse or neglect of a child, elder, or dependent adult
4. If I am ordered by a court to release records or as otherwise required by law
5. If you are using a mental health insurance policy to pay for your visits, I may be required to provide certain diagnostic and treatment information in order to obtain payment for services
6. To coordinate services with your primary care provider, your psychiatrist, your referring doctor and/or other relevant providers as stated in the HIPAA regulations

All treatment records are the property of this therapist and will be stored in a secure electronic health record. You may submit a written request for your records, and I will determine whether it is appropriate to release these records.

Therapist Contact Between Sessions: You may call or email me between sessions for brief questions, concerns, or scheduling matters. I am not always able to answer the phone, so please leave a voicemail and I will make an effort to return your call within 48 hours. In the case of a psychiatric emergency or crisis, for Travis County residents, please call Psychiatric Emergency Services: (512) 472-4357. For Williamson County residents, please call the Crisis Intervention Team at (800) 841-1255. In case of immediate emergency, please call 911.

Email: Email should not be used for a crisis or emergency situation as you may not receive an immediate response. Security of email cannot be guaranteed, and you may wish to avoid the transmission of confidential information in email. If you choose to email me, you are accepting this risk.

Text Messages: Text messaging should be used for scheduling issues only. If you need to discuss anything else between sessions, please call and leave me a voicemail.

Questions and Other Rights: If you have any questions about the above information or other questions related to your treatment, please feel free to discuss this with me. If you are unhappy with your treatment at any time, I hope that you will talk with me so that I can address your concerns. You have the right to considerate, safe, and respectful therapy, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

Client Signature

Date

Parent/Guardian/Conservator Signature (if applicable)

Date

Parent/Guardian/Conservator Signature (if applicable)

Date

Therapist/Witness Signature

Date