Informed Consent for Counseling and Psychotherapy

Therapist

The undersigned therapist is a licensed professional engaged in providing mental health care services to clients directly as an employee of West Texas Counseling and Guidance. The undersigned therapist has discussed with me the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. I understand that I may withdraw from treatment at any time but if I decide to withdraw, I will discuss my plan with my therapist.

Mental Health Services

West Texas Counseling and Guidance recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move toward resolving your difficulties. The therapist will strive to help you grow toward greater health and wholeness by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our counselors work within the context of each individual's beliefs, and no attempt is made to impose a personal theology.

Appointments

Appointments are made by calling 325-944-2561, Monday to Friday between the hours of 8:00 am and 5:00 pm. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits

Therapy sessions are 50 minutes in length, but may take longer for the initial session.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you.

Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Goals, Purposes, and Techniques of Therapy

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting goals of your therapy. As therapy progresses, these may change.

Cancellations

Cancellations must be received **at least 24 hours before** your scheduled appointment; otherwise **you will be charged the customary fee for that missed appointment**. You are responsible for calling to cancel or reschedule your appointment. Your therapist reserves the right to cancel your appointment if you show up sick or with minor children that might interfere with the counseling session.

Payment for Services

The charge for your initial session is $115.00 and the charge for any subsequent session is $100.00. **The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges**. Different copayments are required by various group coverage plans. Your copayment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the copayment may be different for the first visit than for subsequent visits. You are responsible for and shall pay your copay portion of the undersigned therapist's charges for the services at the time services are provided.

Although it is the goal of the undersigned therapist 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**. In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate of $100.00 per hour for giving that testimony. Such payments are to be made at the time prior to the time the services are rendered by the therapist. The therapist may require a deposit for anticipated court appearances and preparation.

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 of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; fee disputes

between therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority. FOR FURTHER INFORMATION, REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT.

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed 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 the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in a position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons:

This information is to be provided at my request for use by said persons to prevent harm to myself or another person. This authorization shall expire upon the termination of my therapy with the undersigned therapist.

I acknowledged that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this observation. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the NOTICE OF PRIVACY PRACTICES of the undersigned therapist that I have received and reviewed.

I acknowledge that I have been advised by the undersigned therapist of the potential of the re-disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule.
I further acknowledge that the treatment provided to me by the undersigned therapist was conditioned on my providing this authorization.

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 upon the quality of the efforts of both of our parts and the realization that you are responsible for the lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

After-Hour Emergencies

A mental health professional is on call when your therapist's office is closed and can be reached for emergencies on a 24-hour, seven-days-per-week basis, by calling 325-653-5933. Emergencies are urgent issues requiring immediate action.

Therapist's Incapacity or Death

I acknowledge that in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file or records. By signing this information and consent form, I give my consent to another licensed mental health professional in West Texas Counseling and Guidance to take possession of my files and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

Consent to Treatment

I, 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.

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.

Contact Information

I consent for the undersigned therapist to communicate with me by mail, e-mail, and phone at the addresses and phone numbers provided by me at my initial appointment, and I will IMMEDIATELY advise the therapist in the event of any change.

Notice of the West Texas Counseling and Guidance Privacy Practices

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information.

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a **legal responsibility** under the laws of the United States and the state of Texas to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on April 14, 2003 and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will effect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at West Texas Counseling and Guidance. These changes could also effect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you.

If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance, which we will provide at no charge to you. *Here are some examples of how we use and disclose information about your health information*. We may use or disclose your health information…

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff,

improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.

6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.
7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that is necessary to respond to the emergency.
8. To the appropriate State agency if, we suspect the neglect or abuse of a minor or adult. If, in our professional judgment, we believe that a patient is threatening serious harm to another, we are required to take protective action, which may include notifying the police, or seeking the client's hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization.

We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization.

We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of the West Texas Counseling and Guidance, <u>you have these important rights</u>:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You can ask us for photocopies of the information in part "A" above.

C. You will not be charged for copies made here at the Center and picking them up. If you need copies of your health information due to a Third party request, we will charge a fee of $25.00 for the first 10 pages, then $1.00 for each additional page.

D. You have a right to a copy of this notice at no charge.

E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if you request that we contact you on an alternative phone number other than your residence, or if

your primary language is not spoken at this Center) Your written request must specify the alternative means and location.

F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

G. You can make a written request that we amend the information in part "A" above.

H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.

I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before April 14, 2003.

K. If you request the accounting in "J" above more than once in a 12-month period we may charge you a fee based on our actual costs of tabulating these disclosures.

L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person: Dustin McCoy, Compliance Officer, 242 N. Magdalen Street, San Angelo, TX 76903. Telephone: 325-944-2561 | Fax: 325-653-4218.

M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

Authorization to Release /Exchange Information

Client: _____ SSN: _____

Information to be Mutually Released Between:

West Texas Counseling and Guidance *and* _____
242 N. Magdalen _____
San Angelo, TX 76903 _____
_____

I, _____, authorize the release of the following information between the parties named above:

__ Progress in Treatment
__ Diagnosis
__ Psychological Test Results
__ Psychosocial History
__ Treatment Summary
__ Treatment Attendance
__ Medical Information
__ School Information
__ Verbal Communication (concerning content counseling record and sessions)
__ Other _____

This authorization is effective from date signed for: __ 6 months, __ 1 year, __ 2 years.

I understand the meaning and purpose of this release, and that the released information may be provided in written and/or verbal form.

Client (or Legal Guardian): _____ Date: _____

Witness: _____ Date: _____

RECEIPT: ***West Texas Counseling & Guidance***

If signing for a minor child, please print child's name: _____

Signature of Parent/Guardian _____ Date _____

I, _____ *acknowledge that I have received signed copies of the Informed Consent* **and** *Privacy Practices* forms from my therapist on the _____ day of _____, 201____ (today's date).

Client Signature: _____

As witnessed by: _____ (Therapist) _____ (Date)

West Texas Counseling & Guidance Center **Date**: _____

CLIENT PSYCHOSOCIAL HISTORY

The information requested on this form will be kept confidential, and will help your counselor to assist you. Please fill out the form as completely as you can. Use an "**X**" or ✓ or **N/A** indicate your choices. Write in words or numbers where asked.

Client General Information

Last Name_____ First Name _____ Middle Initial ____

Birth Date: ___ /___ /___ Social Security Number _____ Gender: Male/Female *(circle)*

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home telephone: _____ Cell phone: _____

May we call you? Yes / No *(circle)* May we leave a message? Yes / No *(circle)* E-mail: _____

Name of Legal Guardian (if under 18 years): _____ Cell number: _____

Name of Mom: _____Cell number: _____

Name of Dad: _____ Cell number: _____

Referred by: _____ Reason for referral: _____

_____

Reason for choosing West Texas Counseling & Guidance of San Angelo?

_____

_____

Religion/Denominational preference: _____ Congregation (if any): _____

Racial/Ethnic identity: ___ African American ___ Native American ___ Asian American

___ White/Caucasian ___ Hispanic/Latino ___ Pacific Islander ___ Other: _____

Emergency Contact: _____ (name) Contact number: _____

Relationship to the client: _____

Employment and Education

Are you employed full-time? Yes / No *(circle)* Home-based business? Yes / No Homemaker? Yes / No

Are you unemployed? Yes / No Are you employed part-time? Yes / No

Employer: _____

What type of work do you do? _____

Highest Level of Education completed: □ High School □ Associate's degree _____ (major)

□ College degree _____ (major) □ Graduate degree _____ (major)

□ Professional training _____ □ Other _____

Family Information

Are you?: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed □ Cohabiting

Parents: *Mother Father Guardian (circle)*: Living, age ____ Deceased (circle)

Mother Father Guardian (circle): Living, age ____ Deceased (circle)

Siblings: Number of Brothers [ ] Ages of Brothers [ ] Only Child [ ]

Number of Sisters [ ] Ages of Sisters [ ]

Names and ages of your children: _____

Names and ages of your step-children? _____

Who lives at home with you? _____

Have any of your children died? *(please provide details)* _____

Have you or anyone in your family experienced domestic violence or abuse? Yes / No *(circle)*

Have you or anyone in your family experienced mental health problems? Yes / No *(circle)*

Have you or anyone in your family sought counseling for drug or alcohol abuse? Yes / No *(circle)*

What do you consider the most significant events in your life? _____

Do you drink alcohol? Yes / No *(circle)* On average, how many drinks do you have? ____ per day/week

Do you use drugs? Yes / No (circle) If so, which ones? _____

If you do use drugs, how often do you take them? _____ times per day/week *(circle)*

What would you like to see happen as a result of psychotherapy or counseling?_____

_____

What is your reason for seeking help now? _____

Are any of the following conditions a problem to you at this time? *(Check the ones that apply)*

_____ Anxiety	_____ Self esteem	_____ Loss of meaning in life
_____ Grief	_____ Stress	_____ Loss of faith in God
_____ Depression	_____ Substance abuse	_____ Conflicts at work
_____ Irrational fears	_____ Chronic fear	_____ Religious doubts
_____ Nervousness	_____ Guilt feelings	_____ Sexual orientation
_____ Loneliness	_____ Loss of hope	_____Other? _____
_____ Anger	_____ Rage	_____
_____ Marriage problems	_____ Relationship to parents	_____
_____ Sexual problems	_____ Relationship to children	_____

Medical History

Name and address of your physician: _____

When was your last medical examination? _____

Are you suffering any physical illness or symptoms at this time? _____

_____

List major surgeries or illnesses in the last five (5) years: _____

_____

List current medications: _____

_____

Have you or any member of your family received help for drug or alcohol dependency? Yes / No *(circle)*

When? _____ Name of helping agency: _____

Have you ever received psychotherapy or counseling?↑Yes / No *(circle)* When? _____

Name of treating therapist: _____

Do you have thoughts of harming yourself or others? Yes / No *(circle)*

If so, are thoughts of harming yourself or others a frequent occurrence? Yes / No *(circle)*

Do you dwell on these thoughts and wonder if you can control them? Yes / No *(circle)*

Have you sought professional help because of these thoughts or feelings? Yes / No *(circle)*

Acknowledgement

Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

_____ _____

Client's signature Date

May 2013

NO SHOW & CANCELLATION POLICY

When you schedule an appointment with our staff, West Texas Counseling & Guidance reserves that time just for you. That is why we require **24-hour advance notification of cancellation**. Leaving a message on our voicemail is fine, even on weekends. The time you called will be posted with the message. Should you fail to show for your scheduled appointment or cancel less than the required 24 hours in advance, you will be charged the fee of **$25** for missed sessions. If you are being seen for reduced fee and pay less than $25 per session, the fee will be your usual session charge. We appreciate the courtesy you extend to us by honoring this agreement. Please note that we **cannot** bill your insurance company for missed sessions or for late cancellations. You will not be seen again by your therapist until the fee is paid.

If we are billing Medicaid, an Employee Assistance Program, or certain third parties, the $25 fee may not be applicable. In this case, after **two** no shows or cancellations within 24 hours of your appointment time, you will not be allowed to reschedule an appointment. You may be placed on a call- back list to be seen the same day.

If you have **three** no shows or late cancellations within a calendar year, you may be discharged from services.

By signing this agreement I acknowledge my understanding of all the policies listed above.

I, the undersigned, accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.

_____

Signature of Client **Date**

_____

Signature of WTC&G Staff **Date**