Consent for Services and Treatment

Thank you for choosing to receive your therapy services from me!

This contract is a reciprocal agreement with corresponding rights and responsibilities on both sides.

THE COUNSELING RELATIONSHIP

All Psychotherapists are required to adhere to the Code of Ethics and Standards of Practice as put forth by the Texas State Board of Examiners of Professional Counselors. This code precludes dual relationships in order to protect the rights of the patients and maintain the objectivity and professional judgment of the provider of services. In the event that a relationship outside the therapeutic relationship is unavoidable, I will discuss the situation with you and resolve the issue with you professionally and in a manner most suitable to your needs.

_____**Initials**

LIMITS OF CONFIDENTIALITY

While HIPAA and the Right to Privacy Act bind all providers of Mental Heath Services, there are limitations. Some specific limitations of confidentiality are:

- When the patient waives their right to privacy and gives written consent,
- When disclosure is required to prevent clear and imminent danger to the patient or others,
- In matters affecting the welfare or abuse of children, and
- When ordered by an official of the court as required by law.

In the event of a treatment team, supervisory status, or peer review, you will be informed prior to services being rendered, of every person who may have access to the file or information pertaining to you. In the event of one of the above stated instances, I will disclose only what is essential information required by the given circumstance.

Laws have been enacted for your privacy. It is important to know that emails and phone call interchange, including text messaging are not secure or guaranteed for privacy because they can potentially be intercepted. Therefore, by signing this document you understand that if we have correspondence by email or phone/text, there is a potential for confidentiality to be compromised.

_____**Initials**

FINANCIAL ARRANGEMENTS

Fees for services are **$160.00** per session or as determined by your insurance plan. However, out of pocket fees may be adjusted individually, based on your needs and when agreed upon by me. If for any reason you cannot make your payment/co-payment for services, please discuss this with me; ***services will not be rendered unless you have done so***. I will do my best to work with you on adjusting your fees to fit your needs.

I accept most credit cards, **some** Medicaid, and some insurance. If possible I will file insurance claims for you. If I am unable to file the claim for you or you are having difficulty with your insurance forms, please let me know so that I can assist you.

If for any reason you cannot make a scheduled appointment, please contact me 24 hours prior to your appointment to avoid being billed $90.00 for the missed service (excludes Medicaid patients).

_____Initials

FOCUS OF SERVICES

All patients have the right to be informed of the goals and purposes, techniques, procedures, limitations, possible risks, and the benefits of services to be performed. Goals of treatment and procedures to be used will be agreed upon by you and me. This is usually done in the first or second session, after I have obtained an extensive psychosocial history from you. This history enables us to complete the most effective treatment plan and set appropriate goals for therapy. You are encouraged to ask questions about any of the aforementioned aspects of the services to be provided. You have the right to have such questions answered in terms clearly understood by you.

Therapeutic treatment procedures may include, but are not limited to, homework assignments, role-playing, written assignments, assertiveness training, or social skills training. During the course of your individual therapy other recommendations may be suggested, such as participation in group therapy, 12-step recovery or other support groups. Should this happen, I will try and supply the information necessary to facilitate the recommendations. With some therapies there are possible side effects and some risks are involved. Therapy is often emotional and draining for the individual and things may appear to get worse before they get better. Anxiety may result from dealing with and facing emotional issues. Relationships may change as you make changes in your personal life and gain increased insight and understanding. As a result of your therapy sessions, I may recommend you see a psychiatrist to evaluate the need for medication.

If for some reason you would like to terminate your therapy I will explore alternative choices with you and make appropriate recommendations if desired. Some alternatives to therapy may be 12 step recovery programs, support groups, services offered by churches or community centers in your area, inpatient treatment, or support of family and friends.

Appointment duration, times, and frequency will be determined based on your individual needs. ***Generally, appointments will last 50 minutes and being late for an appointment by 20 minutes or more may require that you reschedule.*** The duration of therapy will be determined by your progress, the desired goals of the intervention, treatment type, and mutual agreement between us. We will decide when to terminate therapy based on your needs. In the event that I feel I am unable to assist you, when it is clear you are no longer benefiting, when services are no longer meeting your needs, or you are not willing to pay the agreed upon fees for services, therapy will be terminated. ***I may also terminate therapy in the event you have missed three appointments without calling to cancel 24 hours prior to the scheduled appointment. I will attempt to contact you with your latest contact information to inform you of termination.*** You have the right to terminate therapy at any time for any reason.

Upon termination of therapy I will assist you in finding other services or another therapist, when necessary. Closure is an important part of the therapeutic relationship for both the provider and the patient. For this reason I encourage a termination appointment for all patients that are ending individual therapy.

I do not use video or tape recording devices without your prior consent. You have the right to have access to and view your records at any time. However, these records are maintained and owned by me. Access to these records are limited to all other individuals unless given prior consent by you, when required by law, and in situations involving minors, under the age of 16.

_____**Initials**

I, Debbie Edmunds, MA, LPC-S, CART am a member in good standing with The Texas Counseling Association (TCA). You can reach the TCA at 512-472-3403.

The terms and conditions of this contract can be renegotiated upon your request or at my discretion at any time.

If at any time you have a problem or complaint against me that cannot be resolved between us, the general complaint line for Mental Health providers in Texas is 1-800-821-3205 or you may also contact the Texas State Board of Examiners of Professional Counselors, 1100 West 49th St., Austin, TX 78756-3183. Their number is 1-512-834-6658.

I _____ have read and

Patient Signature or Parent/Guardian signature if patient is a minor

understand the above guidelines of the informed consent. I have been given the opportunity to ask questions and have been informed of the rights of confidentiality and my rights as a patient. I understand that the contract for services portion of this contract can be renegotiated at any time by my request or consent. I agree to the treatment, procedures, and goals of therapy as discussed with the provider. I have received a copy of the informed consent and the contract for services.

_____

Patient Name (please print)

_____

Patient Signature or Parent/Guardian signature if patient is a minor **Date**