

SHENA TUBBS, M.MFT, LPC

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

As a provider, I am 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 clients and maintain the objectivity and professional judgment of the provider of services. In the event that a relationship outside the therapeutic relationship is unavoidable, the provider of services will discuss the situation with the client and resolve the issue with the client professionally and in a manner most suitable to the client's needs.

LIMITS OF CONFIDENTIALITY

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

- When the client waives their right to privacy and gives written consent,
- When disclosure is required to prevent clear and imminent danger to the client or others,
- Legal obligation such as child or elder abuse, cooperating with CPS, law enforcement officers, etc.,
- When ordered by an official of the court as required by law,
- Information required by insurance companies for payment (for which you consented),
- Information provided to parents if the client is a minor,
- Valid collection of a debt, and/or
- Consultation with other professional in order to aid in the counseling/therapy process (identifying information will be withheld unless written permission is given).

In the event of one of the above stated instances, the provider of the services will disclose only what is essential information required by the given circumstance.

Release of information to other individuals, agencies, or professionals may only be done with your written consent. 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.

You have the right to have access to and view their records at any time. However, these records are maintained and owned by myself. Access to these records are limited to all other individuals unless given prior consent by the client, when required by law, and in situations involving minors, under the age of 16.

Initials _____

FINANCIAL ARRANGEMENTS

Fees for services are **\$125.00** per session for individuals, couples and families (45 minutes). Divorce mediations and child custody agreements are **\$150.00** per hour with a minimum of 2 hours.

If for any reason you cannot make a scheduled appointment, please contact our office 24 hours prior to your appointment to avoid being billed \$125.00 for the missed session. Payment in full for all professional services is due at the time of the service whenever face-to-face. You (or parent/guardian) are directly responsible for payment. **Checks should be made payable to Shena Tubbs, M.MFT, LPC.** It is helpful to have checks made out prior to the session.

Returned checks are subject to a **\$35** service fee which must be paid prior to the next appointment, and future payments will be required to be made with cash or money order. Because payment is due when services are rendered, I usually do not send bills. If, however, a situation necessitated that you be billed, please remit payment within five days of receiving the invoice. Should payment problems arise, they must be worked out openly and quickly. Such problems can greatly interfere with the therapy progress and working relationship.

Initials _____

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Insurance:

Insurance reimbursement is not accepted as a primary method of payment. However, you may be eligible for “out of network” benefits, but you will need to research your coverage to make this determination. You are responsible for completing and filing the necessary paperwork for insurance reimbursement in such a situation. I will provide you a receipt for services rendered. Please let me know if you intend to access your insurance benefits as additional information, such as a specific diagnosis, is usually required.

Other services include phone calls over five minutes, generating reports, consulting with other agencies and professionals at your request, paperwork and depositions resulting from a subpoena, and the time spent performing any other services you may request. These services will be charged as they occur. I do not testify in court cases unless under subpoena to do so.

FOCUS OF SERVICES

All clients 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 the client and the provider. This is usually done in the first or second session, after the provider has obtained an extensive psychosocial history from the client. This history enables the provider and the client to complete the most effective treatment plan and set appropriated goals for therapy. Clients are encouraged to ask questions about any of the aforementioned aspects of the services to be provided. Clients have the right to have such questions answered in terms clearly understood by the client. 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 therapy other recommendations may be suggested, such as participation in 12-step recovery or other support groups. Should this happen, the provider will supply the information necessary to facilitate the recommendations.

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 self-knowledge and understanding. If needed, I may recommend you to 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. **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 contact you with any form of your latest contact information to inform you of termination.** Closure is an important part of the therapeutic relationship for both the provider and the client. For this reason I encourage a termination appointment for all clients that are ending individual therapy.

Appointment times and frequency will be determined based on your individual needs. **Being late for an appointment by 20 minutes or more may require that you reschedule. The session will end at the scheduled time, regardless of late start, unless the late start is at the fault of the therapist.**

CONTACT OUTSIDE OF SESSION

You will be given my cell phone number in order to cancel appointments or for emergencies as needed. Therapy will not be provided via email, text messaging or social media. Specific coaching may be available in times of crisis for up to 15 minutes otherwise regular session prices will be charged. I encourage you that in cases of life threatening emergencies, to go to the emergency room nearest you or call 911.

If I leave for an extended period of time you will be given the information for another licensed therapist with whom you may schedule if you need an appointment during your therapist's absence.

Skype, telephone, and web conferencing for counseling are allowed if you are within the state of Texas and there is completed intake paperwork on file. Initial session must be face to face.

MINORS & PARENTS

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Clients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them (if requested) only with general information about the progress of your treatment, and your attendance at scheduled sessions. If requested, I could also provide your parents with a summary of your treatment when it is complete. Any other communication to your parents will require your Authorization, unless we feel that you are in danger or are a danger to someone else, in which case, we will notify your parents of concern. You will always be notified of this ahead of time and be given the opportunity to reach out first to improve communication. In cases of divorce, a copy of the divorce decree indicating parental rights to view records and participate in treatment will be required.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE WAS MADE AVAILABLE TO YOU.

Minor Name

Minor Date

I, _____, have read and understand the above understand the above guidelines of the informed consent. I have been given the opportunity to ask questions and have been informed of the rights if confidentiality and my rights as a client. 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.

Client Name (Please Print)

Client Signature or Parent/Guardian Signature if client is a minor Date