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INFORMED CONSENT

The following is an agreement entered into between the above therapist and _____ (as client).

The modalities of outpatient psychotherapy utilized in my office are widely accepted forms of psychological treatment. As with all forms of clinical treatment however, there are risks to be considered in the process of making an informed decision. This form is designed to inform you of these risks as well as the potential benefits of outpatient therapy, and to discuss the general policies and procedures of my office.

Overview of Clinical Services

During treatment, we often use a variety of outpatient treatment modalities which include individual, family, marital, and group psychotherapy. Our treatment approach is based upon each client's specific clinical needs as identified during the initial session(s). The client's therapy options are then discussed and a plan for treatment is determined. A client's needs sometimes change over the course of their outpatient therapy, which may necessitate a reevaluation of their treatment plan. When this occurs, treatment options are once again discussed and determined by the client and therapist. If, at any time, the client and/or therapist believe the client's clinical issues require alternative or additional resources, every effort will be made to assist the client in locating these resources. While therapy should end through mutual agreement once desired goals have been reached, you have the right to end therapy at any time. Please feel you always have the right to ask questions of me. Therapy only works if you have trust and confidence in me and feel my respect and concern for you.

Benefits and Risks of Treatment

The risks or potential side effects of participating in psychotherapy may include increased levels of stress and anxiety, escalation of undesired behaviors, relationship disruption, and emotional reactivity. The benefits of outpatient psychotherapy may include improved functioning in your personal and professional relationships, improved communication skills, and a reduction in the symptoms which led you to seek therapy in the first place.

Office Policies

1. Payment in the form of check or cash or credit card is due at the beginning of each appointment.
2. As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied.
3. Most insurance plans require a diagnosis as part of filing a claim. This diagnosis will be discussed with the client prior to providing a statement.
4. If you are using insurance, you are responsible for your co-pay as required by your insurance company. The session length may change slightly as dictated by the terms of your insurance company. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time.
5. Cancellation of an appointment for Individual, Marital, or Family therapy requires 24 hours advanced notice. (Advanced cancellation of Monday morning appointments should be made on the therapist's cell phone.)

Otherwise, the client will be charged **$50.00** for the missed session. Emergencies (death in the family, hospitalizations, etc. will be addressed on a case by case basis).
6. If you are using insurance and cancel with less than 24 hours notice or do not show-up for the appointment, ***you, not your insurance company***, are responsible for the missed session ($85.00).
7. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. If after 90 days the fees are still unpaid within the above terms, the client's account may be turned over to a collection agency. The client or responsible part will be held responsible for any collections fee charged to my office to collect the debt owed.
8. Session duration is fifty (45) minutes. The fee per session is $85.00. Sessions longer than 45 minutes will be prorated accordingly based upon this per session rate. (After hours or emergency calls will be billed on the same basis)
9. If you need to reach your therapist prior to scheduled therapy sessions, you can leave me a message at 832-831-8379 or email them at mail@hartwellbs.com. Your therapist will return your call/ email as promptly as possible. If your therapist am out of town, a designated colleague will be on call and can be accessed. At that time, the colleague's emergency contact information will be left on my voicemail message. If at any time, you are unable to get a response and your need is urgent, please contact your physician, 911, or go to the nearest emergency room.
10. The Hartwell Clinic, PLLC is not responsible for child care. If the client is under the age of 16, a parent/ guardian must accompany the minor and remain on-site for the duration of the appointment.
11. **Under the Texas State Board of Professional Counters, Title 22, Texas Administrative Code Chapter 681.41- A copy of the custody agreement or court order, as well as any applicable divorce decree shall be maintained in a client's records for a minor who is named in a custody agreement or court order. Therefore, if there is a custody agreement it must be brought to initial appointment.**

I have received a copy of my fee schedule. (Please initial) _____

Signature(s)_____ Date_____

Confidentiality and Emergency Situations

Please understand that all records, written information, or any electronic data are marked CONFIDENTIAL and are kept under lock and key. No one inside or outside the office will have access to your case except for me. This applies as well to the other therapists in the office.

Information shared with a therapist is held in confidence. A signed and dated Release of Information (which clearly defines the nature of information to be shared, to whom and for how long) is required as consent to disclose confidential information. If the client is a minor, the release must be completed, signed, and dated by a parent or legal guardian. In counseling children or adolescents, confidentiality is a necessity; as much as possible, in order for the therapeutic process to work. While you as parent or guardian have a legal right to information, I will speak with you in a general way unless there is a danger to the child's life. This is conveyed to the child as well. Usually I ask the child and parent to meet with me together so that the parent can voice concerns or ask questions.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the office to have a counselor paged. If no call is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. The Hartwell ClinicCounseling, PLLC will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.

Limitations to Confidentiality

Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by The Hartwell Clinic, PLLC. State Law, we am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the office to have a counselor paged. If no call is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. The Hartwell Clinic, PLLC will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.

1. Texas State Law requires any therapist to notify the legal authorities if you provide information indicating that you are abusing children, the elderly, or if you express intent to harm yourself or another person(s).

2. If a client reveals to the therapist any evidence of professional misconduct (e.g., sexual involvement) perpetrated by a previous clinical provider, the current therapist is required to report this information to the state licensing board for that clinician.

Failure of the treating therapist to report in either of the aforementioned circumstances is a breach of legal and ethical standards which can lead to prosecution and/or loss of licensure.

Signature(s)_____ Date_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no inform will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____

CLINIC:_____

ADDRESS:_____

_____

PHONE:_____

Signature(s)_____Date_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s)_____Date_____

May we contact you at home (circle one) **yes no**? May we contact you at work **yes no?** May we contact you by cell phone **yes no?** Where may we contact you _____?

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ may be treated as a client by The Hartwell Clinic, PLLC. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Signature(s)_____Date_____

Complaints

An individual who wishes to file a complaint against this therapist may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
or call 1-800-942-5540 to request the appropriate form or obtain more information.

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Summary

I have read and fully understand the information provided in this document regarding the various services provided by this office and the potential risks and benefits of outpatient psychotherapy. I also understand the obligations and limitations of confidentiality within the context of the client/therapist relationship. I agree to make payment at the time of service. I agree to cancel appointments only in the event of extreme necessity and I understand that I will be charged full fee unless I provide 24 hours advance notice. I understand that I can leave therapy at any time and if I choose to do so will be assisted by the therapist in finding other clinical resources if any are desired.

By signing this document, I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. If I decide to terminate treatment I will discuss termination before ending treatment. Before you sign below, please ask any questions you may have of this document.

Your signature acknowledges agreement and understanding:

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Signature of Therapist Date

_____
Client's Initial that a copy of the above signed form has been provided