CONSENT FOR TREATMENT & SERVICES

Welcome to Houston Psychotherapists, Inc. This document is Consent for Treatment and Services. It contains important information about our professional services and business policies. Please read it carefully. We will answer any questions you may have when we meet. This document represents a reciprocal agreement between us with corresponding rights and responsibilities pertaining to both sides. Please be advised that this agreement becomes official only after you have signed this document and presented for your first appointment.

Overview of Psychotherapy

Houston Psychotherapists, Inc. is a group of licensed mental health providers and includes licensed psychologists, licensed clinical social workers, and licensed professional counselors, all of whom are trained to provide psychotherapy. The primary goal of psychotherapy is to resolve those concerns for which clients seek treatment. This generally involves assisting the client in making desired changes to thoughts, feelings, or behaviors through the use of various psychotherapeutic techniques. Your provider may utilize a wide range of psychotherapeutic techniques including, but not limited to, in-session exercises, collaborative discussions, and homework assignments. While psychotherapists are trained in a broad spectrum of techniques, it is important that clients be informed that there is no guarantee of improvement or that a specific therapeutic goal will be achieved. Although there is no guarantee of improvement, your provider will work with you to collaboratively create a treatment plan intended to achieve the best possible results. If, at any time, you feel dissatisfied with your services or have any questions about treatment, please inform your provider who will work to resolve your concerns. If, at any point, you (or your provider) have concerns about the effectiveness of your services at Houston Psychotherapists, Inc., additional treatment options and/or referrals will be provided.

Therapeutic Process

The psychotherapeutic process generally begins with the provider obtaining a thorough history (initial intake) from the client, followed by a discussion of therapy goals and objectives including a plan for treatment. The length of time needed to achieve the goals listed on the treatment plan varies widely, but often requires about six to twelve weekly 45-minute sessions. Throughout the course of treatment, progress toward goals will be periodically assessed and changes will be made to the psychotherapy process as needed.

Initial Intake

The initial intake may involve the use of psychosocial interview techniques and/or psychological tests and assessments for the purposes of providing diagnosis and treatment recommendations related to the client's presenting concern or referral questions. Assessments may also address other areas of mental health functioning to provide the most comprehensive evaluation possible.

Risks and Benefits

Clients have the right to be informed about the risks and benefits of the psychotherapeutic process. Benefits from the psychotherapeutic process may include improvement in an area of functioning or achievement of a psychotherapeutic goal. The psychotherapeutic process also involves risks to the client. These risks may include, but are not limited to, the experience of negative emotions. For example, a client may experience anxiety related to a behavioral change that is discussed, or sadness related to a traumatic experience that is discussed. Sometimes, clients experience negative emotions prior to, or concurrent with, positive change. If (or when) a client experiences negative emotions or other risks related to the psychotherapeutic process, this should be discussed with the provider.

The Therapeutic Relationship

The therapeutic relationship between client and provider is a professional relationship and not a social relationship. For example, your provider cannot attend social gatherings or accept gifts from clients. If, by chance, a client sees the provider in public, the provider will not make an obvious acknowledgement of the client in order to protect confidentiality. Your provider also does not give guidance outside of his or her specialized training, and therefore, cannot advise clients on legal, medical, or financial issues. Due to the nature of the therapeutic relationship, it is inadvisable to engage in therapeutic relationships with more than one psychotherapeutic provider at a time. Therefore, your provider is unable to provide psychotherapeutic services to individuals who are already the "identified patient" with another provider of similar services. If you are already receiving similar services, please bring this to your provider's attention immediately so that options may be discussed.

Coordination with your Prescribing Physician

Providers at Houston Psychotherapists, Inc., do not prescribe medications, but may recommend that you consult with a physician regarding the potential benefits of medication. The provider will consult with the prescribing physician to facilitate continuity of care, provided an authorization to release information is signed by the client.

Limits of Confidentiality

Psychotherapy and psychological assessment involve the disclosure of personal information by the client to the provider. Your provider and all of the Houston Psychotherapists, Inc., associates and staff members are bound to keep all disclosed information private and confidential with the following exceptions:

1. Your provider is concerned that you are in imminent danger of harming yourself or others.
2. You disclose information related to the welfare of children, the disabled, or the elderly.
3. You disclose sexual misconduct by a mental health professional.
4. Confidential information is required for insurance or billing purposes.
5. Confidential information is required by law to be released.
6. The client sues the provider.
7. Clients provide written permission for providers to release information.

Records

Clients have the right to access and view records at any time. However, these records are maintained and owned by Houston Psychotherapists, Inc. Access to client's medical records is denied to all other individuals unless the client has given prior written consent. Access may, however, be given when required by law.

Collateral Participants (Family members, friends, etc.)

If more than one individual plans to participate in therapeutic appointments, one of the participants must be the "identified patient." This is the individual who will sign this document, and be indicated as the client. All documents associated with therapeutic appointments will appear in the client's medical record. The client holds rights to obtain his or her own records. For purposes of this document, a collateral participant will be defined as any person (generally a family member) who wishes to participate in therapeutic services with the client. If the client intends for the collateral to participate in therapeutic services, the client must first provide formal and written authorization for release of information to the intended collateral. The collateral participant does not hold a right to the client's medical record unless expressly authorized by the client. The collateral participant may be required to sign an additional consent form.

Termination of Services

Termination of psychotherapy services will be primarily based on the client's progress toward treatment goals. Clients have the right to terminate services at any time and for any reason. If a client desires termination, the provider will offer necessary referral sources. The provider will discuss termination with a client when it is believed that psychotherapeutic services are no longer an effective treatment modality. All active clients must have a pending appointment, even if scheduled weeks into the future. Clients without a pending appointment may be considered inactive and termination procedures may be followed.

Providers at Houston Psychotherapists, Inc., reserve the right to terminate services in the following events:

1. A client has missed two or more consecutive sessions without following cancelation procedures.
2. A client has missed three or more consecutive or non-consecutive appointments in any eight-week period regardless whether or not cancelation procedures were followed.
3. A client misses a scheduled appointment and has made no further contact with the provider for two or more weeks (ex: the client does not call to cancel, does not call to re-schedule, and/or does not respond to the provider's attempts to re-schedule the appointment.)

Prior to termination in the above instances, our providers will encourage you to engage in pre-termination counseling and discuss appropriate referrals. In the above instances, the therapeutic relationship will be officially terminated and the termination will be documented in the client's file. No services will be provided following termination. Should a client wish to re-establish services, they may do so by contacting the provider. There is no fee associated with re-establishing services. Houston Psychotherapists, Inc., reserves the right to deny re-establishment of services to clients whose services have been previously terminated should the provider believe that outpatient psychotherapy services are an ineffective treatment modality at the present time. If services are, for any reason, terminated, clients are encouraged to engage in pre-termination counseling (at no cost, if necessary) and discuss referral options prior to termination.

Fees and Financial Arrangements

Houston Psychotherapists, Inc., offers a standard fee of $150.00 for the initial intake and $150.00 for each subsequent 45-minute psychotherapy appointment. The fee schedule for other services is available upon request. Fees may occasionally be individually adjusted based on client income and/or need. Adjusted fees are mutually agreed upon by the client and provider prior to the initial appointment. If Houston Psychotherapists, Inc. will be billing your insurance company, we cannot adjust your fees. Fees and/or co-pays are due at the time that services are provided. Houston Psychotherapists, Inc. reserves the right to charge any outstanding balance on the client's credit card on file.

Professional Fees

It will be up to the client to pay Houston Psychotherapist the following fees for service that is requested either by the client or any court order**. Short or Long-term disability paperwork**, **Legal reports, trial preparation, etc.: $275.00 per hour billed in 15 minutes increments, with a minimum of a half hour.**
Transportation time for court appearances: $150.00 per hour
Court appearances, and depositions are $275.00 per hour with a minimum of 4 hours.

Limitations of Services

Our providers do not prescribe medication. Generally, psychiatric medications are prescribed by a psychiatrist or primary care physician. Additionally, our providers do not provide legal or forensic services, and, therefore, do not work with the court system or participate in their clients' legal proceedings in any way other than what might be required by law. If you have questions regarding whether or not you will be requiring legal services from your mental health provider, please bring these concerns to our attention immediately. If appropriate, your provider may refer you to a forensic psychologist who is better trained and prepared to address any legal needs that you may have.

Communication

Our providers do not provide therapeutic services over the phone, text message, email, or otherwise between sessions in an effort to protect clients' privacy and maintain professional boundaries. Communication outside of scheduled appointments is generally limited to administrative concerns such as re-scheduling an appointment or obtaining medical records. Messages for our providers may be left with reception or voicemail and are generally returned during the provider's specified office hours. Messages are not generally returned when the provider is out of the office, or on holidays, weekends, or after hours. Our providers do not communicate with clients' family members or acquaintances unless this communication has been explicitly discussed in session with the client and a formal and written authorization for release of information has been signed by the client.

Emergency Services

If you are experiencing a life-threatening emergency, please call 911 or go to the nearest emergency room. Our providers do not provide emergency mental health services; these services are generally provided by emergency room staff. If you are experiencing distress that is not life-threatening, and you would like to contact your provider for a sooner appointment, please do so by calling our office. Your provider will make every effort to offer you an appointment as soon as is feasible during your provider's normal business hours.

Consent for Treatment and Services

I have read and 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 client. I understand that this contract for services can be re-negotiated at any time by my request or consent.

Printed Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

NEW PATIENT INFORMATION

General Information

Clinician Name:
Patient Name:
DOB:
Age:
Address:
City and Zip Code:
Email Address:
Phone number where we may leave a message:
Secondary phone number:
Sex:
Marital Status:
Who may we contact in case of a medical or mental health emergency?
Name:
Phone:
If the patient is a minor:
Parent Name:
Phone:
Address:
Who is financially responsible for services and/or the insured party: Patient Parent
Psychiatrist Name and Phone:
Primary Care Physician Name and Phone:

Insurance Information

Name of Insurance Company:
Name of Insured:
Insured Person's Relationship to Patient:
Insured Person's Date of Birth:
Policy Number:
Mental Health Claims Phone:

Credit Card Information (Required of ALL clients regardless of billing or payment arrangements)

Cardholder's Name:				
Card Type:	Visa	Discover	American Express	Master Card
Account Number:				
Expiration Date:				
Verification Number (three numbers on back of the card):				
Zip Code for Card's billing address:				

I authorize Houston Psychotherapists, Inc., to keep my credit card on file and charge my credit card for the **cancelation fee ($50.00**) **for any appointment missed or canceled with less than 24 hour notice as well as for any outstanding balance upon termination.** I understand that this authorization is valid for one year unless I cancel the authorization through written notice to Houston Psychotherapists, Inc.

Printed Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

AUTHORIZATION FOR COORDINATION OF CARE

Coordination of care involves communication between your mental health care providers and medical providers for the purposes of increased diagnostic accuracy and improved treatment outcomes. Increased communication between health care providers may improve the quality of the services that are provided to you. Many insurance companies are now encouraging or requiring that care be coordinated when services are billed by a mental health care provider. At Houston Psychotherapists, Inc., coordination of care generally takes place between your mental health provider (therapist, counselor, or psychologist) and the provider who prescribes your medication/s (psychiatrist, primary care physician, referring physician, etc.) Topics generally discussed for the purposes of coordinating care frequently include diagnostic impressions, treatment intervention outcomes, and medication changes. We encourage you to provide written consent for your care to be coordinated.

Please list all medications: _____

Prescribing Physician/s:

1. Name: _____
2. Phone:_____
3. Fax: _____
4. Physician's Specialty (psychiatrist, primary care, etc.): _____
5. Did this physician refer you to us or suggest that you seek counseling? _____

I, _____, authorize my Houston Psychotherapists, Inc., provider, _____, to disclose and receive relevant information pertaining to my care and treatment from the above listed provider/s.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that in any event this consent shall expire sixty days after the date of client discharge unless another date is specified.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Signature of Client/Legal Guardian: _____
Date: _____

IMPORTANT INFORMATION ABOUT OUR CLINICIANS

Houston Psychotherapists, Inc., is comprised of many clinicians who hold a number of different educational degrees and licenses to practice as a psychotherapist. Please take note of your clinician's specific degree, training, license and regulatory board information. If you are unsure of your clinician's name, please inquire at reception.

Sammie Jones, Owner: Master's Degree in Clinical Psychology; Licensed Professional Counselor; License Number 16683; Regulated by the Texas State Board of Examiners of Professional Counselors. The Texas State Board of Examiners of Professional Counselors may be contacted at (512) 834-6658.

Kristen Berglund: Master's Degree in Clinical Psychology; Licensed Professional Counselor; License Number 65110; Regulated by the Texas State Board of Examiners of Professional Counselors. The Texas State Board of Examiners of Professional Counselors may be contacted at (512) 834-6658.

Fatimah Escobar: Master's Degree in Counseling; Licensed Professional Counselor; License Number 67476; Regulated by the Texas State Board of Examiners of Professional Counselors. The Texas State Board of Examiners of Professional Counselors may be contacted at (512) 834-6658.Licensed Chemical Dependency Counselor Intern; License Number 3352; Regulated by the Licensed Chemical Dependency Counselor Program. The Licensed Chemical Dependency Counselor Program may be contacted at (800) 942-5540.

Carla L Taylor-Guice: Master's Degree in Educational Counseling; Licensed Professional Counselor; License Number 65582; Regulated by the Texas State Board of Examiners of Professional Counselors. The Texas State Board of Examiners of Professional Counselors may be contacted at (512) 834-6658.

Shawn Hirsch: Doctoral Degree in Educational Psychology. Licensed as a Psychologist; License Number 33413; Regulated by the Texas State Board of Examiners of Psychologists. The Texas State Board of Examiners of Psychologists may be contacted at (512) 305-7700.

Jennifer B Jessen: Master's Degree in Psychology; License Number 66398; Regulated by the Texas State Board of Examiners of Professional Counselors. The Texas State Board of Examiners of Professional Counselors may be contacted at (512) 834-6658. Licensed Chemical Dependency Counselor; License Number 11810; Regulated by the Licensed Chemical Dependency Counselor Program. The Licensed Chemical Dependency Counselor Program may be contacted at (800) 942-5540.

Brett Ritchie: Master's Degree in Counseling; Licensed Professional Counselor; License Number 67164; Regulated by the Texas State Board of Examiners of Professional Counselors. The Texas State Board of Examiners of Professional Counselors may be contacted at (512) 834-6658.

Should you have any questions or concerns regarding the credentials of your clinician, please discuss your concerns with your clinician.

Signature of Client/Legal Guardian: _____
Date: _____

Notice of Privacy Practices and Acknowledgements

I understand that, under the Health Insurance Portability& Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Authorization for the Release of Information

Client Name: _____ Date of Birth: _____

I, _____ authorize _____. to disclose and receive information relevant to my care and treatment with the individual named below:

Person to whom information may be released: _____

Address: _____

Phone: _____ Fax: _____

Information Authorized to be Released (Please check all that apply):

___Information pertaining to Scheduling, Billing, and Administrative Concerns

___Diagnosis, Treatment Plan, and Progress

___Bio-psychosocial History and Background

___Information pertaining to Substance Use

___Information pertaining to HIV/AIDS

___Copy of Testing and Assessment Records

___Copy of Complete Medical Record

___All of the Above AND Any and All Information Requested

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has already been taken. This consent shall expire 90 days after the date of client discharge unless another date is specified.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

Signature of Client/Parent/Legal Guardian: _____

Date on which information may be released: _____

Date on which authorization is revoked (OPTIONAL): _____