For internal use only
DIAG _____
A/C _____
_____

Mental Health Clinic of Greenville
PO Box 377; Greenville, TX 75403
301 Interstate Highway 30, Suite 100
Greenville, TX 75402
Phone: 903-274-4140 Fax: 877-310-9115

THERAPY AGREEMENT AND INFORMED CONSENT

This Therapy Agreement is for:

Client's Name _____ DOB: _____

List all parties in family or couples' sessions: _____

Address _____

City_____State _____Zip _____

List all Phone #_____(Cell/Wk/Hm) _____(Cell/Wk/Hm)

If Child/Adolescent Include:

Parent/Guardian Name_____

Parent/Guardian Address_____ City _____State _____Zip _____

Parent/Guardian Phone # _____(Cell/Wk/Hm)_____(Cell/Wk/Hm)

Co-Parent/Guardian Name_____

Co-Parent/Guardian Address _____City _____State _____Zip _____

Co-Parent/Guardian Phone # _____(Cell/Wk/Hm) _____(Cell/Wk/Hm)

Emergency Contact _____ Phone _____

Relationship to Client (i.e. Parent, Spouse, Son, Daughter) _____

Insurance Comp _____ Ins Provider Phone/MHCD # _____

Ins/Member ID _____ Group ID _____ Place Employed_____

Member/ Insured Name _____ SSN _____ DOB _____

Client Name _____ SSN _____ DOB _____

Relationship to Insured (i.e., Spouse, Son, Daughter) _____

Is there a lawsuit or custody suit pending, or is there a probability of a lawsuit being filed regarding the problem for which you are seeking counseling? Yes ____ No ____
If yes, please explain: _____
_____
_____

We would like to congratulate you on taking the initial step in recognizing your desire for change and our potential in helping you make that change. We hope you as a client will benefit from our services. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, state and federal laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

MY THERAPIST- CREDENTIALS

Ruth Whitely, PhD, LPC-S, NCC, BCN has a doctoral degree in counseling from Texas A&M University-Commerce. She is licensed as a Professional Counselor Supervisor (LPC-S) from Texas State Board of Examiners of Professional Counselor's. She also maintains a National Board of Certified Counselors Certification (NCC). She is Board Certified in Neurofeedback (BCN) from The Biofeedback Certification International Alliance.

Steven Neal, MS, LPC has a master's degree in counseling from Texas A&M University-Commerce. He is licensed as a Professional Counselor (LPC) from Texas State Board of Examiners of Professional Counselor's.

Gail Fry, MS, LPC has a master's degree in counseling from Dallas Baptist University. She is licensed as a Professional Counselor (LPC) from Texas State Board of Examiners of Professional Counselor's.

COUNSELING INTERNS- CREDENTIALS

It is my understanding that this facility uses interns who are under supervision as counseling interns. The interns all hold Masters degrees in counseling and are Licensed Professional Counselor Interns (LPC-Intern) from ***Texas State Board of Examiners of Professional Counselors***. Information included in your file (e.g., intake form, progress notes, videos, etc.) is shared with their supervisor, Ruth Whitely PhD, LPC-S, NCC, BCN. You are responsible to pay for the services of interns directly your insurance company is not billed.

EMERGENCY SITUATIONS

This clinic is **NOT** an emergency or crisis treatment provider. If you have an urgent situation that arises, you can leave a brief but detailed message & can expect a call within 24 hours (your therapist will always attempt to respond to you as soon as is possible). If you have a true or life-threatening emergency, please call 911 or if appropriate go to the nearest hospital; Glen Oaks Hospital (903) 454-6000, Green Oaks Hospital (972) 991-9504 for indigent care or Garland Behavioral (972) 487-5309

NATURE OF PSYCHOTHERAPY AND THE THERAPEUTIC RELATIONSHIP

Therapy can help you better manage the challenges of daily life. Discussion of your specific goals and progress will be a central part of the therapy process. Therapy often requires the sharing of difficult thoughts and feelings and you may feel uncomfortable at times. Sometimes, the feelings may become intense. At other times, you may feel that you are not making enough progress. It is especially important during difficult times that you continue to put your thoughts, feelings, and impulses into words. We will work together to consider options available to help you meet your therapy goals.

Although your sessions may be very emotionally and psychologically intimate, it is important for you to realize the professional nature of this relationship. Our contact is limited to the paid sessions we have at the office. None of our providers will be able to attend social gatherings or relate to you in any way other than in the professional context of therapy sessions. Our experience demonstrates that clients are best served if the therapeutic relationship remains professional and sessions concentrate on your concerns.

If we ever see each other in public, you may initiate contact with your provider and say hello at any time. Our provider may not initiate contact with you in order to protect your confidentiality. If we happen to see each other at the same time, our providers generally acknowledge you by smiling, waving hello, and then moving on. During any public interaction, please keep conversation limited to greetings and brief social discussion.

Further, our providers cannot have any personal or economic relationship with you other than our professional relationship associated with your therapy.

OUR PHILOSOPHY OF PSYCHOTHERAPY

Our providers generally see psychotherapy as a co-created process designed for your personal growth and healing. Our theoretical approach is primarily based on cognitive therapy, and we have been influenced and have incorporated the work of many well-known psychological theorists.

Therapy is an opportunity to heal wounds, walk through grief, and discover and create your best self. Ultimately, you have the responsibility for your own healing and growth. The more work you do while in therapy the more powerful your results may be. Your provider is present to assist you through this journey, but it is your journey.

TREATMENT OUTLINE

The Assessment Phase of treatment relies primarily on interview, observation, and background information, and will typically reveal both strengths and weakness. It is used to form a professional opinion regarding possible issues and to formulate appropriate treatment and/services. Evaluation tools are administered and interpreted to supplement the Assessment Phase. These tools are used to provide additional information and insight.

The Treatment Phase begins with a treatment plan, in which specific goals and methods of treatment are identified. Progress in treatment occurs at different rate for different people. Sometimes treatment may cause stress and anxiety. Please communicate if you experience any discomfort. We will set realistic goals together and decide who you will address your issues and concerns.

CONFIDENTIALITY AND DUTY TO WARN

Confidentiality and privileged communications are the rights of all clients, and we exercise every effort to maintain these rights. Information included in your file (e.g., intake form, progress notes, assessment information, etc.) are maintained and **privy** to the **facility**; Mental Health Clinic of Greenville; and the **counselors**; Ruth Whitely PhD, NCC, BCN, LPC-S, Steven Neal M.S., LPC and Gail Fry M.A. LPC; and the **interns**, and **other professionals** at our facility involved in your treatment or as required for billing purposes (See fee policy).

Records request: No client records will be released directly to parties other than the client or client's parent or guardian. Should information be requested from an outside source, every effort will be made to notify the client of the request. Records shall not be released without the written permission of all family members participating in therapy, or unless required by law. The client may request copies of their own records in writing (form provided upon request). Per HIPAA guidelines the clients' records will be available two (2) weeks after receipt of written request. Per HIPAA guidelines I understand I will be charged a reasonable fee for copying the records, but that I will not be charged for time spent locating the records.

We may release information without your consent if the law requires that we do so. Exceptions include:

1. A **court order** is received,
2. An **emergency** that threatens the client's life or the life of another or if there is a probability of immediate mental or emotional injury to the client,
3. If there is **evidence of abuse** and/or neglect (past or present) of any protected member of society (children, Elders, etc.) as victim or perpetrator.
4. A **licensing board** that has jurisdiction over your provider's license compels the release of your records.
5. If you disclose that a previous **therapist behaved in a sexually inappropriate manner**, our providers are legally required to report it to the District Attorney's office and to the appropriate state licensing board. Your identity need not be disclosed if you do not want it.

Our providers consult with other psychotherapists and discuss clinical issues. Our providers may discuss some clinical aspects of your care with them; however, your identity is not revealed during consultations.

ELECTRONIC COMMINICATION & SOCIAL MEDIA POLICY

The primary way to contact your provider is by calling the office at (903) 274-4140. You may leave a voicemail message at this number at any time. Your provider will respond to voicemail messages during business hours, 9:00am – 5:00pm Monday through Friday, unless otherwise agreed to. After hours, you may leave a message and it will be returned the next business day.

Scheduling changes may be communicated by phone, text or email. **All other matters related to therapy are not accepted by email or text messaging**. Please know that your provider will not discuss therapeutic material through email. Your provider may simply respond by inviting you to bring this material up at the beginning of your next session. Please do not send any material via email unrelated to our professional relationship.

Our office has professional social media pages however, to respect the boundaries of the therapeutic relationships established in this office, your provider will not interact with you through social media. Your provider will not accept friend requests on their personal social media accounts, nor will they follow you on social media.

Technological means of communication (telehealth, video conferencing and phone sessions) may be used to facilitate counseling sessions under specific situations. While I understand that my therapist uses anti-virus, anti-spyware, encryption, & other forms of internet security, I understand my provider cannot guarantee that the communications via the Internet are secure. I understand that cell phones are not a secure form of communication, so calls, texts, and any other electronic transmissions may not be secure.

If there are any restrictions in the way that I wish to be communicated with or about, I must inform my therapist in writing of my wishes.

Consent to call an appointment reminder confirmation:

___ yes ___ no Provide number_____

□ Home /VM □ Cell Phone /VM □ Cell Phone Text

Consent to return or initiate emails ____yes ____no

Provide Email _____

Consent to contact client by postal mail _____yes _____no
if different address than one provided _____

CUSTODY AND CONTROL PLAN

In the unlikely event of your provider's death, incapacity, or inability to practice, the Professional's Tax will take custody and control of your entire provider's therapy and billing records. These records will still maintain strict confidentiality as noted above. You will be notified by one of these individuals in writing of this event should it occur. The Professional's Tax is located at PO Box 188, Trenton, TX. 75490.

INSURANCE BILLING

We take some insurance as payment; payment from insurance is contingent upon the insurance company's policies and your coverage. Therefore, I understand, regardless of my insurance benefits, that I alone am fully financially responsible for the fees for the services rendered.

- I authorize my provider to contact my insurance carrier in order to determine eligibility, authorization, and payment for services.
- I hereby authorize the release of diagnostic information, dates of service, treatment plans, session notes and other information necessary by the Provider/Facility to process insurance claims and allow a photocopy of my signature to file insurance claims and treatment plans.
- I understand that if I do not want to release diagnostic information and dates of service to my insurance or payment source. I always have the right to pay for my services myself to avoid the complexities which are described above.
- We ask that every client authorize payment of medical benefits directly to Mental Health with Dr. Ruth and/or Mental Health Clinic of Greenville.
- I understand some services provided here are not billed to Insurance companies. You are responsible for the cost of these services; Equine Therapy, Neurofeedback and services provided by Counseling Interns (LPC-Interns).
- I understand Court appointed counseling is not billed to insurance companies. You are responsible for the cost of these services. Review session fees listed section below.

FEE POLICY

- **Session fees:** Diagnostic Intake $150.00; Individual, Family, Couples Sessions $85.00; Equine Therapy $120.00; Neurofeedback $100.00 fees are for each session.
- **Equine Therapy and Neurofeedback are not billed to insurance companies**. You are responsible for the cost of these services. Neurofeedback is $100 a session. Equine Therapy is $120 a session.
- **Counseling Intern** sessions are not billed to insurance companies. You are responsible for the cost of these services. Counseling sessions with an LPC-intern are $50 a session. If your family is under a Medicaid program the cost is $25 a session. Missed appointment fees are $40 and Medicaid families pay $25 for missed sessions. Interns court fees are $150 an hour (defined under *court fees section* below)
- Due to the demand for our services, we want to inform you about some important policies: I understand my **payment** (regardless of whether it's a copayment, coinsurance, or private payment) **is due at the time of session** unless otherwise discussed & agreed upon ahead of the session.
- If you miss an appointment you will be taken off the schedule, **you must pay any no show fees and outstanding balance before another appointment can be scheduled**. You may also be added to the waiting list, which means there may be a delay before we can schedule you again.
- **Credit card must be provided to receive treatment** and will be charged a missed appointment fee on the day of missed appointment.
- We charge a fee for appointments not met or rescheduled less **than twenty-four (24) hours in advance** of the appointment. M*issed appointment and late cancelation fees are $40*

MISSED APPOINTMENT

To establish services with our clinic we receive your authorization to bill for a missed session fee during the scheduling of the first appointment. **Twenty-four (24) hours-notice is required to cancel an appointment.** Failure to provide notice will result in a missed appointment charge. You will be charged a missed appointment/ late cancelation **fee of $40.00.** Two consecutive missed appointments may result in termination of services.

I _____ authorize Mental health Clinic of Greenville to p**rocess a credit card payment for missed appointments in the amount $40. I authorize these withdrawals during the duration the client is being seen** including the first scheduled appointment until my treatments are terminated by either myself or my therapist.

Credit card number _____ Billing zip code _____

Expiration date (mm/by) _____ Code on back of card (CVV)_____

Signature _____ Signed Date _____

COURT FEES AND SUBPOENAS

Our emphasis is counseling and helping clients identify strengths and resources to overcome crises and life's situations; therefore, we would prefer not to be included in cases involving litigation. Court appearances: include any requested appearance, subpoenaed appearance, settlement conference, or

deposition; require additional fees which are **due at least one week** before the scheduled appearance. Please understand that you not your Insurance Company will be held responsible for court related fees should they occur.

- **Court Fees**: $250 hour (4-hour min; 3 hours court time + 1-hour preparation time) $1000.00 deposit (for case preparation/ court time)
- Additional court time billed at $250.00 in one-hour increments.
- **Counseling interns:** are billed at $150 hour (4-hour min; 3 hours court time + 1-hour preparation time) $600.00 deposit (for case preparation/ court time). Additional court time billed at $150.00 in one-hour increments. Travel expenses paid. If the subpoena includes the intern's supervisor then the supervisor's fees must be paid as well (supervisors fees outlined under *Court Fees* above).
- **Travel Expenses: (**for all professionals) All travel related expenses are required to be paid (e.g., mileage 50¢ mile, hotels, etc.)
- Written case summaries $150 per case summary
- Charges associated with these services will be due immediately and prior to any professionals/parties receiving my therapist's documentation or services
- **Please note**: All appearances require a subpoena.
- **Please note**: if an appearance request is received without a minimum of one-week notice, the appearance fee is due immediately and there will be an additional $250.00 express charge.
- **Please note**: Failure to provide the fee as specified, constitutes legal action to pursue release from the requested court appearance.
- **Please note**: after appearing in court the therapeutic relationship in most situations will be terminated. If your therapist is involved in a litigation appearance the therapeutic relationship/alliance may be jeopardized.
- **Please note**: Any appearance requires the therapist to provide factual accounts of the therapy as well as provide opinions. Both parties and the judge may ask questions. Understand that you may not agree with factual accounts or opinions expressed. This is why we prefer not to participate in litigation.

FUTURE RATE INCREASES

I reserve the right to raise my professional fees. Should this occur, you will be given at least a 60-day written notice of any future fee increase.

TERMINATION OF THE THERAPEUTIC RELATIONSHIP:

The majority of therapy relationships end because clients achieve their goals and agree to terminate. You are free to end therapy at any time for any reason, whether or not your provider thinks it is clinically advisable. Please tell your provider in session that you plan to stop therapy, rather than just not returning, so we can review your progress and discuss any referrals that may be appropriate.

There are a few situations in which your provider may determine the need to end the therapeutic relationship:

- If you no longer need therapy and cannot benefit from continuing, the therapy relationship must end.
- If your needs surpass your provider's ability to help you, your provider must refer you to a therapist skilled to do so.
- If you do not comply with a mutually developed therapy plan, there is no benefit in continuing therapy.
- If you do not abide by the policies and procedures of this practice (as set forth in this agreement), your provider may end the therapy. This includes missing appointments without 24 hours' notice, failing to contact your provider to reschedule missed appointments, or failing to be current in payments or other arrangements.
- If the therapy relationship becomes subject to a conflict of interest that may compromise your provider's ability to protect your confidentiality or remain therapeutically neutral, your provider must refer you to a therapist who does not have such a conflict.
- If your provider ever decides to end the private practice or relocate it to another area.

COMPLAINTS:

If you have a question or concern about your provider, the office, our therapeutic relationship or other questions or concerns related to your therapy; we hope that you are comfortable bringing these concerns to your provider's attention. We will happily work with you to resolve any issue you may have. However, if you believe that your provider has violated the law, you have the right and ability to file a complaint against your provider. You may contact the Texas State Board of Examiners of Licensed Professional Counselors. A written complaint can be sent to *P.O. Box 141369 Austin, Texas 78714-1369 or* one can call for a complaint form at 1-800-942-5540.

RISKS OF THE THERAPY PROCESS:

Sometimes, the concerns or symptoms that brought you to therapy may worsen before improving. In addition, there is the risk that your concerns or symptoms may not improve as a result of therapy.

DISCLAIMER:

No therapist can assure you that you will improve and/or meet all your therapeutic goals. Your provider will utilize their professional judgement and ability to provide you with their best efforts on your behalf.

ADULT CONSENT TO RECEIVE SERVICES:

I _____(**parent(s) or individual**) agree to participate in the counseling sessions offered by Mental Health Clinic of Greenville. As a **parent(s) of children seen** I agree to participate. **Families** list all members of family who may attend sessions.

MINORS CONSENT TO RECEIVE SERVICES:

Child/Children name(s) _____has my permission to participate in counseling sessions offered by Mental Health Clinic of Greenville.

If Minor is listed in any **court proceedings (i.e., divorce, custody)** the order identifies me a managing conservator of the minor.
_____ Yes _____ No (If yes **MUST** provide a copy before we can provide services**)**

All custody agreements must be provided to Mental Health Clinic of Greenville. Should any changes occur in any custody agreement, Mental Health Clinic of Greenville must be notified, and a copy provided at the next session.

AGREEMENT:

By signing below, you are indicating that you have read and understand this informed consent statement and that any questions you have had about this document and/or the therapy process have been answered to your satisfaction. Should any elements of this therapy agreement change, you will be provided a written amended copy. A copy will also be placed in your records after you have had the ability to review it, ask questions, and sign the amended agreement. You are hereby agreeing to enter into a professional therapeutic relationship with the undersigned provider.

Please read the HIPAA agreement included in this packet for full details related to confidentiality and the use of your information. I/we have read and received a copy of the notice of Privacy Practice and Clients' Rights documents.

_____ _____
Adult Client's Printed Name Date

_____ _____
Adult Client's Signature Date

_____ _____
Client Signature Assent ages 11-18 yrs. Date

_____ _____
Parent or Legal Custodian Date

_____ _____
Co-Parent or Legal Custodian Date

_____ _____
Provider Date