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Counseling Services, Policies and Informed Consent

Services and Treatment

Counseling is offered for adolescents, individuals, and families. Of course, the therapy process is different for every person. Some clients may feel they are significantly helped in 6-10 sessions. Others may need longer-term therapy. The number of sessions depends on many factors and will be discussed between us. When I work with pre-teens and teens, my role is to work with the teen and the parents as a team, consulting with parents throughout the counseling process. I provide feedback and support to parents, assisting them with creating a positive environment for growth and change within the family unit. Therapy sessions are 50-60 minutes in length.

Payment for Services

The charge for the initial session is $150. Additional sessions are charged at a rate of $125. By consenting to treatment, you acknowledge that you are responsible for the cost of these provided services to you or your minor child, and agree to pay them at the time of service. If you have insurance coverage, I will be happy to file the claims for you.

Cancellations

In the event that you will not be able to keep an appointment, please notify me at least 24 hours (at least one full *business* day) in advance. ***Otherwise, you will be billed the customary fee for the missed appointment.*** Please be advised that insurance and EAP services do not pay for canceled or missed appointments. Therefore, you will be responsible for the entire fee.

Emergencies

Should you or your child need emergency assistance after hours, you may go to the nearest hospital emergency room, call 911, or call the Suicide & Crisis Hotline at 214/828-1000. For non-emergencies, you may leave a message and I will return your call in a timely manner.

Records and Confidentiality

For insurance claims, your protected health information will be disclosed to your insurance company for the purpose of filing claims and insurance reimbursement. This includes diagnostic information, dates of service, and any other health information your provider requires.

I will keep confidential anything you or your child reveals to me with the exception of the following:

1. *I determine any information revealed in a session indicates physical, sexual, or emotional abuse or illegal neglect of children; or abuse, neglect, or exploitation of elderly or disabled persons.*
2. *I determine you or your child is a danger to self or others.*
3. *I am ordered by the court to disclose information.*
4. *You (parent or legal guardian) sign written consent.*
5. *If you or your child receives concurrent services from another practitioner, we're both obligated to disclose our involvement to one another.*

Concerns regarding ethical questions may be addressed to the following consumer hotline: 1-800/942-5540

Permission for Professional Services for a Minor:

I have legal authority to seek and grant permission for professional counseling services for the minor child listed below with no legal decree disallowing my authority to assume such responsibility.

____________________________________ DOB ____________________________
Child Name

____________________________________ Date ____________________________
Parent/Guardian signature

Adult Consent for Treatment:

By signing this Counseling Services, Policies and Informed Consent form, I the client, acknowledge that I have both read and understand all of the terms and conditions contained herein. I have had ample opportunity to ask questions and seek clarification of anything unclear to me.

____________________________________ Date ____________________________
Client – print name

____________________________________ Date ____________________________
Client – signature

____________________________________ Date ____________________________
Counselor signature