***Therapy***

I understand that there is a possibility of risks and benefits which may occur in any mental health settings. Therapy may involve the risks of remembering unpleasant events and may arouse strong emotions. Therapy can impact relationships with significant others.

For therapy, my first session will be an assessment, with therapy commencing with the second session. The clinician will discuss therapy goals with me at that time.

The benefits from therapy may include an improved ability to relate to others; improved cognitive processing; a clearer understanding of self, relationships, values, goals; increased productivity; an enhanced ability to deal better with everyday stress. Taking personal responsibility for working on these issues may lead to greater growth.

If for any reason I leave or am discharged from seeing the clinician, they will no longer be my therapist. The clinician will provide appropriate referrals to other therapists or agencies if I need them at the time of discharge.

Initials \_\_\_\_\_

***Minor Clients***

If you are the parent or guardian and are requesting services for your child/adolescent under the age of 18, I will need your permission to provide counseling services to him/her. Keep in mind while you have the right to question and understand the nature of your child/adolescent’s sessions, treatment is usually more effective if your child/adolescents develops a level of trust with me so if you agree, I will only provide you with a general overview of each session along with our child’s progress. However, there are limits to confidentiality (listed under “Confidentiality”).

Initials \_\_\_\_\_

***Confidentiality***

I understand that while information related to the sessions is confidential, the clinician will not provide or disclose any information about my treatment or therapy without my written permission, except as may be required by law under the following circumstances:

1) if there is an imminent threat of harm to self or others

2) there is an indication of abuse of a child, disabled/dependent adult, or elderly adult

3) by court subpoena

4) as required for billing, insurance, reporting, or auditing purposes by licensing or other agencies.

I caution that regular email or any other form of social is not a confidential means of communication. If you or your family attempts to contact me by these means, I cannot guarantee confidentiality.

Initials \_\_\_\_\_

***Release of Information***

If information needs to be released, it will only be done so according to state law and with a written consent from the client. The consent for the release of information can be withdrawn at any time. The therapist reserves the right to use discretion when releasing information, to protect the therapeutic relationship. In the case of marital therapy, the client is the couple, not individuals; therefore, all records can only be released when both parties’ consent in writing or if mandated by the court.

Initials \_\_\_\_\_

***Electronic Communication***

Although electronic communication (email/text) has become a major means of communication between individuals, it has significant limitations. Please note the following guidelines for electronic communication as a form of communication with your therapist.

* Your therapist does not provide personal counseling via email or text.
* Your therapist cannot guarantee that your email/text will remain confidential. Although your therapist may keep your email message private, your therapist cannot ensure administrators of the system and experienced computers may be able to access email, so confidentiality cannot be ensured.
* Although email/text may seem like a fast way to contact someone, your therapist may not have the ability to check email/text as frequently and as consistently. Please call your therapist on the designated business line to ensure communication.

Initial \_\_\_\_\_

***Professional Records***

Upon request, you may review your counseling records. You will be asked to arrange an appointment with your therapist to review your records. You may be charged a full or partial session fee for administrative costs/time related to preparing copies of your records. Counseling records are maintained for 10 years after your last contact with your therapist.

If you are requesting a written letter for any purpose relative to counseling services provided, the therapist is not mandated to provide you with such a letter. The therapist understands in some circumstances, a letter is beneficial/necessary. Requests for written letters will be taken under consideration immediately, however, a letter will not be written or provided until the client has attended a minimum of 3 counseling sessions. The therapist reserves the right to decline writing a letter based on clinical judgement.

Initial \_\_\_\_\_

***Fees***

Therapy sessions are $120 per 50-minute session. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. If I am an in-network provider for your insurance carrier, I will bill in accordance with their policy less any applicable co-payments. If I am an out-of-network provider, the client is responsible for payment at the time of service and may then submit bills to his/her insurance provider for reimbursement. I will provide you with assistance for you to receive the benefits to which you are entitled.

Fees for professional services:

* Preparation of records, letter writing (for employers, teachers, MD’s etc.) - $50 per hour
* Attendance at meetings of phone consultations with other professionals (that you have authorized) - $100 per hour
* Court appearances - $100 per hour

Initial \_\_\_\_\_

***Cancellation Policy***

My goal is to provide quality service to all clients in a timely manner. Failure to keep scheduled appointments (no-shows) is costly to our office and you. Patients who are unable to keep their appointments are requested to give a minimum of 48 hours’ notice prior to their appointment time. Providing such notice allows our office to offer other persons the opportunity to see a clinician, thus using the time more efficiently. Should I need to cancel your session for any reason you will not be charged. If you have already paid for a session cancelled by me, that fee will be applied to your next session.

* If an established patient fails to provide notice of a cancellation of their appointment prior to 24 hours before their appointment, a $50 fee will be billed to his/her account for each missed appointment. A third missed visit will result in discharge of the client.
* If a new patient fails to show up to an appointment without any notice, they will incur a $60 no-show fee.

Name on Card: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Initials \_\_\_\_\_

***Teletherapy***

I understand that therapy conducted online is technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside of my control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, I agree to call my therapist back at 678-883-6151.

I TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I a solely responsible for maintaining the strict confidentiality of my user ID and password and to allow another person to use my user ID to access the Services. I also understand that I am responsible for using technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Initial \_\_\_\_\_

***Emergencies***

My confidential voicemail is (678) 883-6151. It is always available to for leaving messages when I am in session or out of the office. ***If an emergency arises when I am not available to speak with you, please call 911 and/or present to the nearest emergency room.***Crisis Intervention Houston, (713) 468-5463, provides 24-hour crisis intervention services.

Initial \_\_\_\_\_

***Right to Terminate Therapy***

While I strive to partner with all my clients, I do understand that there may be circumstances when you or I need to terminate therapy. In most circumstances, we will be able to determine together when therapy is not a good fit or complete, and thus a smooth transition. At any time, the client or clinician may terminate the relationship and referrals to other therapists can be provided, who may be a better fit to provide services.

Initial \_\_\_\_\_

***Reporting Ethical Concerns***

Should you need to report any Licensed Professional Counselor to their licensing board for ethical violations, please contact:

**Texas State Board of Examiners of Professional Counselors**

**1100 West 49th Street**

**Austin, Texas 78756-3183**

**512-834-6658**

Initial \_\_\_\_\_

***Electing to Self-Pay***

Despite being insured, I do not wish for Essential Health, LLC., to submit a claim to my insurer for services provided to me. I elect to self-pay for all services received from Essential Heath, LLC. I understand services and payments made will not be credited towards satisfying any deductible I have under my health insurance plan and I agree to not submit claims later.

Disagree \_\_\_\_\_ Agree\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

***Payments from Insurer***

The insurance company listed below will be billed for this and all future appointments. I hereby authorize the release of all relevant medical information required in order to process the payment. In case that the payment does not go through I understand that I am responsible for covering the payment. I am also responsible for double checking whether I have a remaining deductible on my insurance plan.

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I voluntarily agree to receive therapeutic services and authorize Essential Health, LLC., to provide such services, that are considered necessary and advisable.

Initials \_\_\_\_\_

I acknowledge that I have read and understand all the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

Initials \_\_\_\_\_

I have had the opportunity to discuss any questions I have about this information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

I have discussed this information with the client.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Elizabeth Lyons, MA, LPC Date