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Personal Counseling & Consulting

Important Information

Please read and sign that you have read and understand the following.

By making your first appointment you have already made progress. Deciding to participate in therapy show your courage and willingness to take the steps necessary to improve your life. Therapy can be rewarding, and those who are willing to work and take the necessary risks can experience a life changing process. We look forward to working with you and hope that we can assist you in reaching whatever goals you set.

Effective Therapy is built from good working relationships and requires mutual understanding. It is in the mutual interest of both client and therapist to convey to you the policies and procedures we use in our practice; we are willing to discuss any questions or problems you may have.

Appointments are usually scheduled once or twice a week and last approximately 53 - 60 minutes. More frequent or intensive outpatient schedules are possible depending upon the circumstances. If you need to reschedule or cancel an appointment, please call (817)459-2003 and leave a message that you need to reschedule your appointment. Broken appointments create a loss to everyone. **It is important that communication of changes be made well in advance of your scheduled appointment time whenever possible; a missed appointment or an appointment canceled without 24 hour notice will result in a $25.00 charge.**

The Fee Schedule is as follows: Fees are based on time and are the same for individuals or couples/families within the same session.

Service	Fee
Initial Intake and Assessment	$150.00
Regular Office Visits (53 - 60 minutes)	$125.00
(1 hour, 15 minutes)	$135.00
(1 hour, 30 minutes)	$180.00
Small Group Therapy (1.5 hours/week) per session	$ 35.00
Outside Office Work (Inpatient visits, court testimony, written deposition etc.)	$175.00/hour
Required Written Reports (Ins. Companies, supervisors, etc.)	$150.00
CORE Multidimensional Assessment Profile	$100.00
ThriveSphere Marital	$ 50.00
Anger Management Group (10 weeks, $30 session, or if prepaid)	$250.00

We do not discriminate on any basis. If we are unable to help with your case, or continued service is no longer in the client's best interest, the therapist will terminate and provide three referrals to other sources.

Payment of Fees: Fees are payable at each session. Monthly payment arrangements are possible for those who have already established a record of paying. Insurance claims will be filed if requested; otherwise, full payment is expected and a super bill will be given upon request for you to file your own insurance. Payment is your responsibility even when insurance is filed. **In order to take full advantage of your session time, it is requested that your check be prepared prior to beginning the session, this also helps to expedite the rescheduling of future appointments.**

Relationship: Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

Emergencies: A mental health professional is on call at Millwood Hospital 817-261-3121.

Therapist's Incapacity or Death: I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me the copies upon request, or to deliver them to a therapist of my choice.

Limits of Confidentiality: Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse, abuse of the elderly or disabled; abuse of patients in mental health facilities, sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this consent form, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing you mental health care services and payment for those services, and you are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

I have read and understood the above limits to confidentiality. Furthermore, I grant permission for my therapist to share my information with any therapist who covers for my therapist when they are unavailable. I also grant permission for my therapist to share my case in a Case Review if they deem it necessary.

Duty to Warn: In the event that the undersigned therapist reasonably believes that I am or my child is a danger, physically or emotionally to myself or another person, I specifically consent for the therapist to contact any person in a position to prevent harm to myself or any other person, including but not limited to the person in danger, and to contact the following persons in addition to medical and law enforcement personnel:

Name Telephone Number

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Consent to Treatment: I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through the undersigned therapist at any time.

By signing this client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Many opportunities have been offered for me to ask questions and seek clarification of anything unclear to me.
This signed copy will be kept in your file; if you want a copy for yourself, please ask and we will be happy to provide one.

___________________________________ ______________________________

Signature of Adult Patient or Parent/Guardian Date

___________________________________ ______________________________

Therapist Date