

CCD Counseling PA
CLIENT INFORMATION AND CONSENT
 version 201609

Your Clinician

CCD Counseling P.A. employs the services of a variety of contract clinicians in an attempt to best meet the needs of our diverse clientele. Your clinician is either licensed by the state of Texas or in the process of completing their licensure and practicing under the supervision of another licensed professional. Each has a licensing board and a Code of Ethics that guide their practice (see list, below). Your Clinician is:

_____, who is licensed as a:

- Licensed Professional Counselor (LPC)
- Texas State Board of Examiners of Professional Counselors (800-942-5540)
- Licensed Clinical Social Worker (LCSW)
- Texas State Board of Social Work Examiners (800-942-5540)
- Licensed Marriage and Family Therapist (LMFT)
- Texas State Board of Examiners of Licensed Marriage and Family Therapists(800-942-5540)
- Licensed Chemical Dependency Counselor (LCDC)
- Texas Department of State Health Services (800-942-5540)
- * Licensed Master Social Worker (LMSW)
- Texas State Board of Social Work Examiners (800-942-5540)
- * Licensed Professional Counselor Intern (LPC Intern)
- Texas State Board of Examiners of Professional Counselors (800-942-5540)
- * Licensed Marriage and Family Therapist Associate (LMFT Associate)
- Texas State Board of Examiners of Licensed Marriage and Family Therapists(800-942-5540)

***Clinical Supervisor:**

(Required for LMSW, LPC Intern, and LMFT Associates): _____

- INTAKE SESSION - CLINICIAN NOT YET ASSIGNED (If this box is checked, client will receive the information about their clinician in their first session).

The Therapeutic Relationship

Your relationship with your clinician is a professional and therapeutic relationship. Our codes of ethics forbid “dual relationships” in which the clinician has another personal or business relationship with you.

We want our clients to be good consumers of mental health services. There are a variety of psychotherapy approaches within our agency. Counseling is a personal issue and you should feel comfortable with your clinician. Please feel free to ask questions with regard to any aspect of your services. If your clinician is not a “good fit” for you, please let them know so they can offer you alternatives either within or outside our agency. Your clinician may also refer you to other or additional services if you are not clearly benefitting from their services.

Your clinician will use their knowledge of human development and behavior to attempt to assist you in reaching your therapeutic goals. There is no guarantee on the outcome of any mental health service. We hope that it will ultimately be rewarding to you, but want you to recognize that you may also experience emotional discomfort along the way. The process of counseling and the choices that clients make as a result may not all be anticipated. An example of an unintended outcome is in couples therapy, during which one or both partners may choose to exercise their choice to end their relationship.

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Sessions

A standard clinical hour is 50 minutes. A play therapy session is 45 minutes. Assessment, Groups and other services vary in their length. Payment is made at the time of service.

Appointments

Each clinician maintains their own schedule and offers appointments at different times. You will probably make your next appointment (if needed) during your current appointment. Cancellations must be made 24 hours in advance or you will be billed for the session.

Number of Visits/Termination

Both the number of visits and frequency of sessions will vary with each case. You should discuss this with your clinician. Termination of counseling is an important issue in counseling and should be planned in advance with your clinician so necessary closure and/or referral to other resources can be offered. Termination by client without clinician consultation is considered "Against Medical Advice."

After-Hours Emergencies

Emergencies are urgent issues requiring immediate attention. If the situation is dangerous, you should take immediate action to create safety, including calling 911.

Caller ID/ Blocked Calls

Please protect our privacy. In an effort to return your calls quickly, your clinician may use a phone at another location, which may be their home or someone else's home. When returning that call, **please do not use the number displayed on your caller ID**, if it is different than the number you have been asked to call. **IF YOUR CALLER ID IS SET TO BLOCK ANONYMOUS CALLS, OR if your cell phone voice mail has never been set up OR is at capacity**, you will severely limit your clinician's ability to return your call. Please provide a number where you can be reached.

Privacy

The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read it before you sign this Consent form. By signing this form you are agreeing to let us use your information here and send it to others. **If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.**

I consent for the clinician and the agency to communicate with me by mail, email and by phone or text at the contact numbers and addresses I provide. I understand that information may be conveyed electronically and the privacy of those various communication methods cannot be guaranteed (e.g. a client's cell phone transmissions speaking with their therapist could theoretically be intercepted; we cannot confirm the identity of the person receiving electronic messages). I further understand that my information is stored electronically and exchanged between staff electronically. CCD has warned me of this and advise me that I should carefully consider what information is delivered by various means, what contact information I have provided, and any special requests that I have about communicating with me or handling my information.

I understand that CCD Counseling PA is the custodian of my record and that in the event of my clinician's incapacity or death, CCD Counseling P.A. will provide me with copies upon request, or deliver them to a clinician of my choice.

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Fees

Individual, Couples, and Family Therapy

The Fee for a “clinical hour” (fifty minute face to face session of individual, couples or family therapy or a forty-five minute play therapy session) is \$100.00. We want services to be affordable for households of various income. We are able to reduce this fee when we can reduce the cost of providing the service. We offer reduced fees for most clients who meet the following criteria:

1. PAY THE FULL BALANCE DUE ON THE DAY OF SERVICE,
2. Have gross annual household incomes of less than \$100,000, and
3. Do not require any documentation for a third party.

Each of these criteria must be met for each and every session for which you wish to have a reduced fee. For example, if you do not pay in full on the day of service, you will be billed \$100 as long as you have an outstanding balance, regardless of any previous reduction in fees.

Any applicable reduced fee is calculated based on the following information about your current household:

of Members _____ Gross Annual Income \$ _____

Other Services

The Fees for other services are set at a fixed rate or at the rate of \$100.00 per hour. The services that you are contracting to receive and their related fees are specified in the “Your Fee” section. Some services have an additional agreement that explains those services and the related fees in greater detail.

Third Party Payment

Your fee, or some portion of it may be paid by a third party. If the agency has a contract with that party, the fee assessed will be according to that contract. While the client retains final responsibility for the payment of all fees for services they receive, the only payment required at the time of service is the portion designated as “Co-Pay” in the “Your Fee” section, on the next page. If a third part is specified, the client is requesting that a third party be billed.

No Show and Late Cancellation

If you are unable to keep your scheduled appointment, please call as early as possible. If you call at least 24 hours in advance of your scheduled appointment, you will not be charged. If you provide less than 24 hours notice, the fee will be \$25.00. If you don’t provide your clinician any notice and “no-show” your appointment, the fee will be \$50.00.

Court Preparation and Testimony

The fee for testifying in court and providing depositions is \$600 per half day (four hours) for the time that the therapist is required to be available (e.g. if the therapist waits outside the courtroom for 4 hours, then testifies for 10 minutes, the fee is \$1,200.) The **minimum fee is \$600** which is due at the time that you or your attorney request the attendance of the therapist. The fee for related activities (e.g. preparing for testimony, travel, reports, etc.) is \$100 per hour.

Miscellaneous Fees

Copying Files	Not to exceed cost
Returned Check	\$25.00

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Your Fee

Self-Pay Client Services

- | | |
|---|-----------------------------|
| <input type="checkbox"/> Clinical Hour | <u>Fee</u>
\$ 100 |
| <input type="checkbox"/> Reduced Fee Clinical Hour (when applicable) | _____ |
| <input type="checkbox"/> _____ | _____ |
| <input type="checkbox"/> _____ | _____ |

Third Party Pay Client Services:

(Specify the 3rd Party)

<u>Service</u>	<u>Fee</u>	<u>Co-pay</u>	<u>3rd Party</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I (We) voluntarily agree to receive Medical and/or Mental Health assessment, care, treatment, or services, and authorize the employees of CCD Counseling P.A. 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 at any time.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have read, understood, and agree to all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. I agree to the use and sharing of my protected health information as described in CCD Counseling PA's Notice of Privacy Practices

Client

Date

Client

Date

In addition to consenting to all of the above, I also attest that I am the parent, legal guardian, or otherwise have the legal right to consent for the medical treatment of the above person. I am not required in a divorce decree or otherwise to have the consent of any other prior to this minor receiving such services.

Parent/Guardian/Custodial Conservator

Date

Clinician or Coordinator

Date