Austin Wellness, PLLC
www.austin-wellness.com
10010 Anderson Mill Rd.
Austin Texas 78750
512-257-0050

CONSENT FOR TREATMENT AND PSYCHOTHERAPY SERVICES AND POLICIES FORM

Please read and initial next to each paragraph below indicating your acceptance:

_____ **CONFIDENTIALITY**: All information disclosed within sessions and the written records pertaining to those sessions are *confidential* and may not be revealed to anyone without your (client or guardian) written permission, except when required by law. The therapist is required to report any known or suspected case of child or elder abuse or neglect and to take action to ensure safety if a client presents danger to self or others.
For educational and professional purposes, the therapist consults regularly with other professionals regarding clients in order to ensure quality of service; however, a client's name or other identifying information is not disclosed. For educational, research or business purposes, the therapist may collect and share information that is "de-identified" (i.e., it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you). Please refer to the HIPAA Notice of Privacy Practices and OMNIBUS Rule and Texas HB300, posted on Austin Wellness, PLLC website, for more information.

_____ **EMERGENCIES**: In case of an emergency, you or someone you trust should call the local emergency room, your medical doctor, or 911. If the therapist assesses you may be at risk to harm self or others, the therapist may contact your Primary Care Physician, your emergency contact, or emergency personnel to advocate for your care and safety.
If the therapist becomes unable to serve or contact you due to personal emergency, serious illness, or death, the following person will be available to help or refer current clients, and manage client records:
_____ Lisa Blackwood MS MA LPC-S #19803 EMDR Certified LCDC #4065 (512) 257 - 0050 x113

_____ **HEALTH INSURANCE, CONFIDENTIALITY, PAYMENT:** If the therapist accepts your insurance, the insurance company will be billed for your psychotherapy sessions. Your health insurance may require confidential information from the therapist in order to process your claims. Your consent is required before releasing the requested information. It is the client's responsibility to verify the specifics of the insurance coverage. If the insurance does not cover a psychotherapy session, it is the client's responsibility to pay for the service.

_____ **YOUR RIGHT TO REVIEW RECORDS, HIPAA NOTICE**: You have the right to review or receive a summary of your records, except in limited legal or emergency circumstances or when releasing information might be harmful in any way. In such case, the therapist will provide the records to a licensed mental health professional of your choice. Considering the above exclusions, the therapist will release information to any entity you specify only upon receiving your written authorization. Please refer to the HIPAA Notice of Privacy Practices and OMNIBUS Rule and Texas HB300, posted on Austin Wellness, PLLC website, for more information.

_____ **LITIGATION LIMITATION**: Due to the sensitive nature of therapy and the information shared and addressed, the therapist is not obligated to supply any documentation, correspondence, or presence regarding any legal proceedings. Should you or your attorney desire any documentation or service for court/legal purposes, the therapist must receive such request in writing and by law have 15 days to give a response. The therapist may decline the request if disclosure of the requested information may be harmful in any way to the client; no request will be acknowledged unless it is accompanied by the client or guardian's written permission. Any documentation, consultation, or testimony requests will incur a charge of $100 per half hour. Testimony charges may include time spent traveling, preparing reports, attendance, and other case related costs.

_____ **DUAL RELATIONSHIPS**: Dual relationships should be avoided whenever possible, especially when ethics or your treatment progress may be in question. Therapy *never* involves sexual or any other dual relationships that may impair the therapist objectivity, clinical judgment and effectiveness or could be exploitive in nature. Should the therapist and client encounter each other anywhere outside of the therapist office, the therapist will not approach you or acknowledge you unless you initiate contact.

_____ **THE PROCESS OF THERAPY**: Participation in therapy can result in benefits to you, changing problematic behaviors, feelings, and thoughts, improving relationships and managing specific concerns or symptoms that led you to seek therapy. Working toward solutions requires effort on your part both in and outside of sessions. Although therapy has been shown to improve relationships and symptoms, it may create uncomfortable or strong feelings in the short-term. During the course of therapy, the therapist is likely to draw from one or more research-based theories of psychological approaches, therapies such as cognitive-behavioral, solution-focused, family systems, Eye Movement Desensitization and Reprocessing, and psychodynamic.

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_____ **MINORS:** Parents have a right to receive progress reports on their child's counseling. However, personal information shared by a child during an individual session will be kept confidential unless it involves imminent danger to the child or someone else. Young people may not confide in a counselor if they believe that personal information will be revealed to their parents. If applicable, the therapist must receive a copy of the most recent divorce decree or custody order at the first session; this is to ensure proper consent, confidentiality and disclosure of information. All parent/guardian parties must be informed of treatment, and all with custody rights must consent to treatment of minor at or prior to the first session. Exceptions to parental consent may apply to minors 16 years or older who present for emergency counseling regarding sexually transmitted diseases, substance abuse, pregnancy issues, and/or are emancipated.

_____ **DURATION, TERMINATION**: The duration of treatment depends entirely on your presenting concerns, treatment goals developed together, and effort toward those goals in and outside of sessions. Therapy is most likely to be successful with your active involvement, honesty, and openness. The client's goals and course of treatment will be discussed periodically, with initial goals and focus developed by the 3rd or 4th session. The therapist requests notice before therapy is terminated in order to process gains made during treatment, and issues to be addressed in the future. Therapy will be deemed "Terminated" if client has met all therapy goals and attends a termination session. The therapist will consider a client "Inactive" if no session has been scheduled or attended for 60 days, unless a different therapy schedule has been agreed upon. Inactive clients may contact the therapist to resume therapy, and will be accommodated according to the therapist current policies, fees and availability at that time.

_____ **PAYMENTS, FEES**: Payment in the amount of your fee is due at each session. The therapist accepts cash, check, or credit card. The fees are $300 for the initial Diagnostic Assessment one-hour session. Subsequent session fees are $200 per 50–60-minute session, $100 per 30-minute session. Session times include approximately 5-10 minutes for the therapist to complete documentation of the session. Telephone conversations, report writing/reading, release of information, longer sessions, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify the therapist if any problem arises during the course of therapy regarding your ability to make timely payments. A fee of $50 will be assessed for returned checks.

_____ Intern Fees: $175 Initial Diagnostic Assessment, Subsequent sessions $125 per 50-minute session.

_____ **PHONE CALLS, EMAIL**: If you need to contact the therapist, 10 minutes is allowed for a returned call without charge. The therapist has a confidential voice mail for messaging. Phone messages and emails are checked Monday - Friday (excluding holidays/vacations). Messages received late in the day may be returned on the next business day. Please email to make, cancel, or reschedule an appointment, or make brief reports about your progress. Therapy issues or crises will not be addressed by email. Text messaging to communicate with the therapist, is not a secure way to transmit information. Please list your preferred email address and phone contact: Email: _____ Phone: _____

_____ **CANCELLATION**: The full fee is charged for "no shows" and appointments cancelled less than 24 hours before the scheduled time. An appointment is considered cancelled when not attended at the agreed time and date. Insurance companies do not pay for missed or cancelled appointments. Payment is due for any missed appointment before or at the beginning of the next session. Credit card information is kept on file with your medical records and charges will be billed for any no show appointments and balances due on your account.
Circle type of card Visa / MC / AMEX - CC#: _____ Exp. Date: _____
V Code on the back OR AMEX 4 numbers on the front: _____ Billing address and Zip Code: _____
Signature for payment approval: _____

CLIENT/GUARDIAN: I have carefully read, understand, and agree to comply with the above policies and information, and consent for treatment and psychotherapy services.

Client Name (Print): _____ Signature: _____ Date: _____

Parent/Guardian Name (Print): _____ Signature: _____ Date: _____
Parent/Guardian Name (Print): _____ Signature: _____ Date: _____

I have discussed the above issues and policies with the client/parent(s). My observations of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent to treatment.

Signature of Therapist: _____ Date:_____

If psychotherapy services are not rendered in a professional and ethical manner, you may file a complaint with the
Texas State Board of Examiners of Professional Counselors.
Texas Department of State Health Services MC-1982
1100 West 49th Street Austin, Texas 78756-3183, USA
Email: lpc@dshs.state.tx.us
Telephone: (512) 834-6658 Fax: (512)834-6677