Chat with Jill

Informed Consent and Practice Policies

Thank you for choosing to enter into a counseling relationship with me. I am honored to have the opportunity to work with you in helping you make positive changes in your life.

Counseling Process and Relationship – I believe that counseling is a collaborative process between a client and a counselor. Participation in counseling involves listening to the counselor, being honest, discussing concerns about the process and completing outside assignments when appropriate. Effective counseling requires that the client and the counselor develop a relationship based on mutual trust and respect. I believe that each client is an individual with unique concerns, strengths and values. Please know that I am a professional that is committed to your welfare.

It is important to understand that we have a professional relationship. Contacts, other than chance meetings will be limited to scheduled appointments. If I see you in a public setting, in an effort to protect your confidentiality, I will not acknowledge you. I will wait for you to speak to me before I acknowledge you.

Initially, counseling often results in the client experiencing uncomfortable feelings or thoughts. Sometimes things get harder before they get better. This experience may affect the client's relationship with family members, spouse, or other significant relationships.

The number of sessions needed will depend upon the circumstances that are taking place in each person's life. Each person's journey is unique. Some clients may require only a few sessions in order to reach their goals while others may take several months or possibly even longer. You, the client, are in complete control. You may choose to end our professional relationship at any time. I will support that decision but request that we schedule and complete a closure session.

Fee - My fee is $150 for a 45 to 50 minute session. Payment by cash, or check is due at the time of your session. **If you choose to use a debit/credit card a $6 to $10 *service charge* is added to your fee depending upon the amount of service** Other fees apply for various services, such as copying records and written reports. **Forensic Rates** - $500.00 per 45 to 50 minutes (or portion of hour) for court testimony or deposition. $200.00 per hour for local travel, waiting and preparation for testimony. For out-of-area court appearance, all transportation and lodging expenses must be paid in advance. Records review, consultation with clients, litigants, attorneys (in person or via phone), reports or any other service provided will be charged at the rate of $200.00 per hour or prorated accordingly. A $1500 retainer will be needed if litigation is to occur. Failure to keep your account current may result in legal action or collection agency intervention. **Initial _____**

Cancellation: There is no charge for appointments cancelled 24 hours in advance of the scheduled time.

Appointments cancelled less than 24 hours ahead of time are charged full fee. *If you have insurance and cancel, insurance does not cover the absence. So for "all insurance" clients if an appointment is cancelled less than 24 hours you will be charged the full fee of what your insurance would have paid.* **Initial: _____**

Insurance – If you are requesting that I bill your insurance, please fill out the Insurance Authorization and Release completely. **You are responsible for all fees not covered or reimbursed by your insurance benefits**, including but not limited to, deductibles, co-payments***, missed appointments, late cancellations***, correspondence/reports or services not approved by your plan. It is your responsibility to determine eligibility and to determine what services are allowable under your plan. If I am not a provider for your insurance plan, you may have out-of-network benefits through your insurance company. If you have such benefits, I can provide you with a receipt that you may submit to your insurance so that you can request reimbursement.

Telephone Accessibility – I make every effort to respond to my messages promptly. Calls are returned during normal business hours. Because technical difficulties do sometimes occur, please call again if you do not receive a return phone call by the end of the next business day.

Emergency Care - If you are experiencing an emergency and need to talk to someone immediately, call 911, a telephone crisis line or go to the nearest emergency room**.** ***Please be aware that when I am out of town there is no on-call back up for my practice.***

Email ***- Please be aware that email is not a secure means for communicating information. Thus, confidentiality cannot be guaranteed through email and it is best that you limit email use to scheduling issues. If you do send an email with other information, I will read it but will most likely wait until your scheduled appointment to respond.*** The client should be aware that it is impossible to protect the confidentiality of client information which may be transmitted electronically, i.e., electronic mail and other information stored on computers connected to the internet, by cordless or mobile telephones and similar telecommunication and computer equipment. Therefore, it is agreed between the client and the therapist that unless the client utilizes encryption and other forms of security protection, the client waives any action legal or otherwise against the therapist and holds the therapist harmless from any interception of client information resulting from the use of the above-mentioned equipment. ***Initial*** _____

Consultation - In order to serve you best, I may desire to consult with colleagues or an expert in a particular area relevant to your psychotherapy. I do that without identifying information so that your privacy is protected.

Privacy Rights - Professional ethics and legal standards require that our conversations and my records (even the fact that you are a client) be kept confidential. However, under the following circumstances, I am legally and ethically obligated to breach confidentiality: (a) If you present a serious imminent danger to yourself or others (b) in cases of apparent abuse or neglect of a child, an elderly person, or a disabled person (c) when required by legal proceedings. If I must breach confidentiality, the minimum amount of information will be revealed—only enough to protect you or others.

If it is your child who is participating in psychotherapy, please understand that the specific content of the session will remain confidential. General reports of your child's progress will be made to you and any information regarding danger to your child will be reported to you immediately.

Finally, if I want to consult with someone about the specifics of your case in order to better coordinate services (i.e. a doctor), you will need to sign a release of information. Continuity of care needs to be addressed by your signing a consent for release of information so that I may let your PCP know that you are involved in treatment. Please review the *Policies and Practices to Protect the Privacy of Your Health Information* for a more extensive explanation of your privacy rights. Please indicate by initialing that you want your PCP notified or not. _____YES _____ NO If yes he will be given a summary identifying that you are in treatment and what the treatment is for.

Complaints – If you have concerns or complaints regarding your treatment, please talk with me first. If there is no resolution there, you may contact: Texas State Board of Social Work Examiners PO Box 141369 Austin, TX 78714-1369 (800) 232-3162 (512) 719-3521.

By signing these policies, I

(1) acknowledge receipt of the *Policies and Practices to Protect the Privacy of Your Health Information*,
(2) understand that the psychotherapists conducting business at 10700 Richmond Avenue ste 147 are all sole practitioners
(3) understand and agree to the stated practice policies as listed above and
(4) give full consent for myself or my minor child, _____, to participate in psychotherapy. I certify that I have the legal right to seek and authorize treatment for myself or my minor child.

_____ _____

Client Signature (or parent/guardian if client is a minor) Date

_____

Print Name