DECLARATION OF INFORMED CONSENT

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Confidentiality

Discussions between the counselor, center representatives, and clients are mostly safeguarded. Usually, no information will be released without the client and/or legal guardian's written authorization unless the information is released to contracted agencies, or as mandated to be released by law**.**

Other exceptions to confidentiality include, but are not limited to the following situations:

- Imminent and substantial danger to yourself or others
- Abuse or neglect of a child or of an elderly or disabled person
- Criminal prosecutions against the counselor and/or representatives
- Subpoena or judge's order
- Civil lawsuits brought against the counselor, or representatives, by you or your family for any reason
- Situations where the Counselor has a duty to disclose or where, in the Counselor's or its representatives' judgment, it is necessary to warn or disclose in an emergency
- Fee disputes between the Counselor and you and/or the family member seeking services (i.e. collection agencies)
- Licensing, certifying, professional association, state department, or governmental entity review boards which are investigating a complaint against the counselor or its licensed representatives
- All persons and agencies mandated or authorized by law
- Managed care and/or insurance carrier including but not limited to Texas Medicaid, private insurance, or other third-party payers responsible for providing my and/or my family member(s) care or services and payment for those services

If you and/or your family members have any questions regarding confidentiality, you should bring them to the attention of the counselor when you and that representative can discuss the matter further.

Consent to Contact for Appointment Changes

I specifically consent for the Counselor and its representatives to contact me or the following person(s) by telephone and/or mail, including leaving a message via answering machine or voice mail:

NAME ADDRESS TELEPHONE NUMBER

1. ____

2. ____

Risks of Treatment

You will be making decisions in conjunction with the counselor about what services you will receive. While receiving these services you and/or your family member(s) may learn things about each other and themselves that you and/or they do not like. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you and/or family member(s) are responsible for lifestyle choices/changes that may result from

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treatment at this center. Specifically, common risks include: couples exercising the divorce option; children or adolescents becoming very angry with their parent(s), caregiver(s), or other family member(s); anxiety; anger; depression; fear; emotional pain and distress; suicide and/or homicide; suicidal and/or homicidal ideation, plans, or behavior; treatment failure; an increase in medical, psychiatric, psychological, and social symptoms.

After-Hours Emergencies

Emergencies are urgent issues requiring immediate action such as thoughts of self-harm. The relationship with your counselor is a professional relationship therefore, phone calls and text messages made after office hours should only be made in time of crisis and payment for these services is expected. Staff are on call when the Center's offices are closed, and can be reached at this number: (469) 525-2498. If the counselor is on vacation the voice mail at this number will provide information on whom to contract for immediate assistance. Please leave a voice message letting the counselor know that this is an urgent issue. Usually after hour calls are not billable to insurance and will be billed to the client at a rate of twice that of normal business hour rates. Normal office hours are 8am to 6pm Monday through Friday. If a client is having a life and death emerge is please go to the emergency to receive immediate care.

Staff Incapacity, Death, or Separation

I acknowledge that, in the event that counselor becomes incapacitated, dies, or separates from the Center, it will become necessary for another Center representative to take possession of the case, file, and records. **By signing this Declaration of Informed Consent form, I give my consent for allowing another Center representative selected by the Center and its representatives to take possession of the case, file, and records, if necessary, to complete, or continue to provide, services at this Center, or to deliver a copy upon my request to an outside agency, to complete or continue services.** Please be advised that you will be charged the customary rate for the copying, labor, and postage of any such files or records if the case is transferred at your request to an outside professional.

Length of Visits

Appointments will vary in length depending on the service given. Assessment and individual counseling appointments are typically 45 to 55 minutes in length.

Relationship

Your relationship with the Counselor is professional and therapeutic. In order to preserve this relationship, it is imperative that the Counselor does not have any other type of relationship with you and/or your family. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Gifts, bartering, and trading services are not appropriate, and should not be shared between you or your family, and the Counselor.

Payment for Services

The charges for services will be billed to your private insurance if applicable. Otherwise, your fee is determined by the Center's fee schedule. **We will look to you for full payment of your account, and you will be responsible for the payment of all charges at the time services are rendered.** Please be advised that various insurance plans require different co-payments. Your co-payment is based on the mental health policy selected by your employer or purchased

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by you. In addition, the co-payment may be different for the first visit than for subsequent visits. You are responsible for and will be expected to pay your co-payment before services are provided. It is recommended that you determine your co-payment before your first visit by calling your benefits office or insurance company.

Cancellations and No Shows

Cancellations and no shows are not billable to insurance and must be received at least 24 hours before the scheduled appointment. You are responsible for calling to cancel or reschedule the appointment or fees will be applied. Medicaid and some EAP companies due not allow fees to be charged for canceled or no-show appointments. If client miss more than 2 consecutive sessions or 3 session in a 90-day period of time, that is consider grounds for discontinued treatment.

Payment for Records/Testimony

Although it is the goal of the Counselor to protect the confidentiality of your clinical records, there may be times when disclosure of the records or testimony will be compelled by law. In the event law requires disclosure of records or testimony, you may be responsible for paying the costs involved in producing the records, and you shall pay the Center's usual and customary hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time, or before the time, the Center and its representatives render the services. There is a minimal 4-hour payment required for any in person testimony provided.

Disability Documentation

If you are requesting forms such as Family Medical Leave Act (FMLA), Social Security Disability, Short Term Disability or similar forms be completed by counselor, please be aware that this is a highly labor-intensive request. These agencies often require multiple peer reviews, behavioral health form completion, and complete client charts be provided to them as often as every two weeks. You will be releasing all information to these agencies for them to do with as they see fit. You will be required to pay for these phone calls, faxes, copies, and form completions each time they are done. See the fee policy for pricing.

Termination

Clients may terminate from therapy for many reasons and the client always have the right to change to a new treatment provider if they wish. The counselor may terminate treatment if the client has completed their goals, no longer appears to be making progress towards their goals, has missed more than two consecutive appointments without notice, acted in a threating or abusive manor towards the counselor or needs a specialized treatment that the counselor does not provide such as substance abuse treatment.

Records

It is a requirement that counselors maintain records of sessions attended. You do have the right to receive a copy of your records. Some fees will apply as stated on the fee schedule. In the course of treatment, people may bring in family members and friends as a part of their treatment. These people will not have access to records unless the client provides written permission for this.

General Consents

- I consent to the use, disclosure, or receipt by Tanya Brown-Davis Counseling Services of health information about me, including information pertaining to mental health and/or related condition for the following purposes: treatment, payment and health care operations.
- I understand that only the person listed as patient on intake forms or their guardian if under the age of 18, has to right to receive or release any protected health care information
- I understand the limits of confidentiality and all of the releases signed in this document.
- By signing this Declaration of Informed Consent form, I (the undersigned client, child, adolescent, parent, and/or legally authorized representative) acknowledge and certify that I have been given a copy of the "Notice of Privacy Practices", I have read or have had it read to me in my primary language, and that I understand the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

______________________________________ ________________

Client/Parent/Legal Guardian **Date**

As witnessed by:

______________________________________ ________________

Staff **Date**

<u>General Consents for Child or Dependent Treatment</u>

I am the parent or legal representative of ___________________________, date of birth ______________, and there are no court documents in effect that prohibit me from signing this consent for treatment. I do hereby authorize the counselor to deliver mental health care services to the minor.

______________________________ ________________________

Signature of Parent/Legal Representative **Date**

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Relationship to Client (parent, guardian, etc)