# *CONSENT FOR TREATMENT, RIGHTS, & RESPONSIBILITIES*

Welcome to The Balancing Place, LLC!

The following document is information for you to best understand the therapeutic relationship and the conditions which you will need to be successful. The therapist-client relationship differs from any other relationship you have ever experienced. Please read the following document carefully and inform me of any questions you might have so we can discuss them. When you sign this document, it will represent a contractual agreement between us.

## PURPOSE OF TREATMENT

The purpose of treatment is to meet your therapeutic goals which will be specifically outlined in your treatment plan. We will determine your treatment plan together once we have established what has brought you to treatment, what you would like to work on, and what you want to accomplish. Treatment plans are reviewed once every three months or whenever necessary to address your treatment needs.

## PSYCHOTHERAPEUTIC SERVICES

Psychotherapy is not easily defined in general statements. It varies depending upon the personalities of the therapist,client, and issues being addressed.. Some of the benefits you may gain from these services are enhanced awareness, emotional understanding of yourself, improvement in your relationships with others, reduction in “problems” or “issues” that brought you to therapy in the first place,psychological flexibility, better overall functioning, greater ability to deal with stress and work through difficulties, improvement in job or school performance, strengthened sense of self and overall sense of well-being. However, there are also risks in therapy. You may experience no change. You will most likely feel worse before you feel better; have an increase in feelings such as anger, grief, sadness, and hopelessness and feeling as if you are having increase conflicts with others as you do things differently.

Therapy is not about visiting your therapist and having them “fix” you, or waving a magic wand to change everything immediately. Therapy is hard work and takes your participation and your commitment to change. Your success is directly dependent upon how much work you put into it and is also dependent upon your understanding of the limitations, benefits, and risks of therapy. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. You have the right to question and/or refuse any therapeutic interventions, suggestions, or directives at any time. Sessions are 50 minutes in duration. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and we will develop a treatment plan together. You should evaluate this information and decide

whether you are comfortable working with me and on the goals developed for the treatment plan.

Therapy involves commitment of time, money, and energy, so you should be very careful about the therapist you select. I consider myself an Acceptance and Commitment Therapist (ACT). We will discuss this form of therapy in more detail during our sessions. If you have any questions about any of my procedures or interventions, you have the right to discuss them whenever they arise. If your doubts persist, I would be happy to help you set up a meeting with another mental health professional for a second opinion.

**CONFIDENTIALITY**

I understand that you are entering into a relationship and perhaps divulging information that you have never talked about before. The information you share during our therapy session is strictly confidential. It will not be divulged to anyone unless you have given me written permission. However, there are a number of exceptions to your confidentiality that I am required by law to divulge when necessary. Please review the following exceptions carefully:

· My services were sought or obtained to enable or aid anyone to commit or plan to commit a crime.

· I have reasonable cause to believe that you are a danger to yourself or others. (The disclosure of this information is to prevent harm to yourself or others.)

· I suspect or have evidence that a minor child (under 18) is currently the victim of abuse. Child abuse means physical injury, other than accidental, inflicted on a child by an adult or other person, sexual assault, cruel punishment or neglect. I am ordered by the court of law to disclose information.

In order to provide you with the best possible treatment experience, I participate in consultation and trainings with other professionals. Unless I obtain written authorization from you, identification is not by name but by circumstance. If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. Please respect the confidentiality of others seen or met in the counseling office or sessions.

**EMERGENCIES**

In the event of an emergency please contact 911 or report to the nearest emergency room. I am available via phone or email between the hours of 8am-9pm. Crisis calls will be billed after the initial 15 minutes to the card on file at **$50 each 15 minutes**. Please leave a message in the event I am unable to answer. I will return phone calls or emails within 24 hours. If you are in danger of

harming yourself please contact the National Suicide Line at 1-800-273-8255.

**INSURANCE**

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with the company to my best ability

In the event a short term disability or leave of absence is needing to be filed, there will be a $40 fee charged for each submission. This fee is for the time and materials submitted each occurence. This fee is not billable for insurance and must be paid prior to submission out of pocket.

**PAYMENT AND CANCELLATION POLICY**

Payment for services is due prior to the beginning of each session in full. Payments may be made by Cash, Credit/Debit Card, Bank transfer, Paypal, or HSA/FSA Account. Due to the mutual respect of time, there is a **24 hour no charge cancellation policy**. **Appointments cancelled 23-12 hours in advance will be assessed a 50% session fee of ($62.50 for individual and $75 for couples/family), appointments cancelled 11-0 hours in advance will be assessed a 100% session fee ($125 for individual and $150 for couples/family).** Two no call/no show appointments will constitute a termination of services in addition to fee assessment. Fees are not able to be billed to insurance and must be payed out of pocket. A credit card is needed to be held on file in the event that an appointment is missed. All credit card information is kept secure and confidential. A receipt will be provided via email or text message for any charges.

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|---|---|
| Name as appears on card | |
| Card Type & Billing Zip code | |
| Card number & Expiration Date | |
| 3 digit Security Code | |

**COMPLAINTS**

If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to the Texas State Board of Professional Counselors.

*Complaints Management and Investigative Section*
*P.O. Box 141369*
*Austin, Texas 78714-1369*

*Ph:* 1-800-942-5540

Signing below signifies understanding and agreement pertaining to the things mentioned above, and receipt of this document. If you would like a copy of this information please feel free to inform me so that I may be able to provide you with a copy.

X _____ X _____

Client Signature

Parent or Guardian Signature