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INFORMATION AND CONSENT STATEMENT

I am pleased that you have selected me as your counselor. This document is designed to inform you about my background and to insure that you understand our professional relationship.

QUALIFICATIONS

*Bachelor of Science of Social Work, 1993
Licensed Clinical Social Worker, 1996*

AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY.

CONFIDENTIALITY: *All information disclosed within sessions and the written records pertaining to the sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.*

When Disclosure Is Required By Law: *Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).*

When Disclosure May Be Required: In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by **all** adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together, or in the future after termination, where I may become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier or anyone else at any time. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the, congress-approved, National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access.

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify me in writing at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: I consult regularly with other professionals regarding my clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

- * Because of the sensitivity of the content of the psychotherapy notes, the notes will not be released to anyone. I will release treatment plan and goals upon written request, unless I conclude that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message with my voice mail (972) 532-9535 and your call will be returned as soon as possible. I check messages a few times a day, unless I am out of town. If you need to talk to someone right away, you can call 911, your local hospital or your treating physician.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of \$125.00 per 45-50 minute session or their copay at the end of each session unless other arrangements have been made. This is payable by check or cash. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments. Not all of the issues, conditions, or problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

If I am requested or subpoenaed to testify in court you will be responsible for my retainer fee even if the subpoena is sent from the opposing side of the case and even if our therapeutic relationship has ended. My fee will be \$200.00 per hour with a minimum retainer of \$800.00. The retainer is non refundable and must be received at least 48 hours before I am due at court to testify. If court gets cancelled or I am released from the subpoena on a day that I have cleared my calendar to testify, you will be charged my regular fee of \$125.00 per hour for the appointments that were cancelled to accommodate your legal case. The hourly rate of \$200.00 will be charged from the time I leave the office until I return to the office. Record copying fees are \$1.50 per page plus a \$125.00 per hour copying fee.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy

requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, spiritual, system/family, developmental (adult, child, family), or psycho-educational.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide I will refer you to another source.

Termination: As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my professional opinion, I cannot help. You have the right to terminate therapy at any time.

Nature of Counseling: During the time we work together, we will meet for approximately 45-50 minute per session. This is a professional relationship rather than a social one. Please do not invite me to social gatherings, offer me gifts, or ask me to relate to you in any way other than the professional context of our counseling sessions.

In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress.

My signature at the bottom of this page constitutes my understanding of the information contained in the "Information and Consent" portion of this intake, receipt of a copy of the counseling agreement to retain for my personal files, and my agreement to the following:

1. FEE AGREEMENT AND CANCELLATION POLICY

- Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment.*
- Fees for all services are due at the time of my appointment by cash, credit card or by check.*
- If you do not cancel my appointment prior to 24 hours, you are responsible for paying the full amount of the session, not just a co-payment. Insurance companies do not reimburse for cancelled appointments.*
- Two consecutive missed sessions without prior notice constitutes a termination of our therapeutic relationship.*
- The regular fee will be assessed for any phone calls lasting longer than 10 minutes.*

2. CONSENT TO TREAT MINOR

- I am the managing conservator and I have the authority to authorize counseling treatments for:
Minor #1 -- Name: _____ age: _____
Minor #2 -- Name: _____ age: _____*
- I understand that minor children are granted the same right to confidentiality as adults in a counseling relationship, therefore, psychotherapy notes will not be released, only treatment plan and goals.*
- I authorize counseling treatments for the minor children listed above.*

I have read the above therapy agreement and give my consent to treatment.

Client Name: _____

Signature: _____ Date: _____