

## Client Agreement and Therapeutic Policies

### Introduction:

This agreement is intended to provide clients with important information regarding my professional services and business policies. This consent form will provide a clear framework for our work together and will facilitate our therapeutic relationship. Any questions or concerns regarding the contents of this agreement should be discussed with me prior to signing it.

### Part I: Therapist Information

#### Professional Orientation:

I provide individual therapy for adults, adolescents, and children. I also provide couples therapy, family therapy, pre-marital therapy, group therapy, and parental training for clients in need of these services. Depression, Anxiety, Post Traumatic Stress Disorder, Grief, Panic Disorders, Low Self-worth, and Relationship Challenges are a few of the afflictions I provide treatment for.

My style of treatment is based in Cognitive Behavioral Therapy. I also integrate Solution Focus, Strategic, and Client Centered approaches. The office is a great setting for therapy to take place- with a serene nature theme it provides a comfortable and peaceful environment for healing to take place.

#### Educational/ Training Background:

I am fully licensed through Texas State Board of Examiners of Professional Counselor and my license number is 70190. In addition, I am nationally certified by the National Board of Certified Counselors.

### Part II: Client(s) Rights

1. You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my approach and methods to you.
2. You have the right to decide not to receive therapeutic assistance from me; if you wish, I will provide you with the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those *already* accrued. I ask you contact me by phone or in person before you make such a decision without prior discussion.
4. You have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would greatly compromise our work together.
5. Therapy involves a partnership between therapist and client. As your therapist, I will contribute knowledge, skills and a willingness to do my best.

Client's Initial's \_\_\_\_\_

One of the most important rights involves confidentiality- within the limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. As your therapist, I am legally prohibited from revealing to another person that you are in therapy with me, nor can I reveal what you have said to me in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality must be set aside as required by law or my professional standards.

**Limits of Confidentiality:**

- a) Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.
- b) If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person, I may warn the intended victim and notify the proper authorities.
- c) If you, as a client, reveal a serious intent to harm yourself, I am ethically bound to do what I can to help maintain your safety, which may involve notifying others who may be of assistance.
- d) If a judge orders my testimony or, in the context of a legal proceeding, you raise your own psychological state as an issue, I may be required to release your confidential information to the court.

**\*\*In all of the above cases, it is incumbent upon me to release only that information necessary to appropriately carry out my responsibilities. Your confidentiality still remains an *ethical priority*.**

**Legal action:**

If legal actions occur in which I am requested or subpoenaed to provide testimony (such as a custody case), you will be responsible to pay me directly for providing the following services: (a) the time spent preparing for the court, (b) the time spent for transportation to/from court, and (c) the time spent appearing in court. Charges for legal services will be billed at **\$ 200.00** per hour. This fee is NOT reimbursable by a Third Party Payer and is therefore the full legal responsibility of the client and/or the client's parent or legal guardian.

**Part III: The Therapeutic Process****Benefits and Risks of Therapy:**

Psychotherapy is a process in which you and I discuss a variety of issues, events and experiences for the purpose of creating positive change so you can experience your life more fully. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. The issues presented by you may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Please address any concerns you have regarding your progress in therapy with me.

Client's Initial's \_\_\_\_\_

**Appointments:**

Your appointment time is reserved especially for you. Therapy sessions are normally 50 minutes. Cancellations **MUST BE** made 24 hours in advance. If you do not notify the counselor of your inability to make the appointment and you no-show, you will be billed **100% of the session fee**. If you notify the counselor of your inability to make the appointment but provide less than 24 hours' notice, you will be required to pay **50% of the session fee**. After 2 missed appointments you will be required to pay in full in advance for your next scheduled appointments. Regular attendance is recommended to ensure continuity and to enhance the effectiveness of the therapy. Insurance and third-party payers will not be billed in these instances.

**Portal, E-Mail, Cell Phones, Computers and Faxes:**

It is very important to be aware that computers, electronic mail, and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. Electronic mail is vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, the emails sent by myself are not encrypted. Faxes can easily be sent erroneously to the wrong address. I only use computers that are equipped with a firewall, a virus protection and a password. The portal will be used for documents.

**Records and Administrative Services:**

I may take notes during session and will also produce other notes and records regarding treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Should you request a copy of my records, such a request must be made in writing. I reserve the right under Texas law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I will maintain client's records for 5 years following termination of therapy. If a client is a minor, records will be maintained for 7 years after minor's eighteenth birthday. However, after 5-7 years, your records may be destroyed in a manner that preserves your confidentiality.

**Professional Fees and Payments:**

We will discuss and establish our fee at the outset of treatment and any fee change will be negotiated in good faith. Payment is expected at the beginning of each session unless we have agreed otherwise. Balances more than 120 days overdue may be subject to collection through the use of a collection agency. However, I will first attempt to make other arrangements with you as needed. In general, it is important to discuss with me any issues that arise in connection with our financial arrangements, so that they do not hinder our working relationship.

Client's Initial's \_\_\_\_\_

**Health Insurance Claims:**

After the intake paperwork is received, we will begin the insurance verification process to determine whether your policy covers mental health treatment. Once we obtain that information from your insurance company, we will contact you to let you know what your policy will cover as well as what your share of costs will be under the terms of your policy. Completion of our online insurance benefits form will provide us all the information we need to determine your benefits. Should we need additional information we will contact you by phone.

***1. I agree BY ENTERING into therapy with Heather D. Vest MS, LPC, NCC I will pay the full fee at each session. If I am late to a session, the length of the session may be shortened, and I agree to pay for a full session.***

Fee Structure:                      per hour

Individuals (Child/Adult)                      \$100.00

Couples/Family Session                      \$120.00

***2. A 24 - hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a \$100/\$120 missed appointment fee. I understand that this will be my responsibility, not that of the third-party payer.***

***3. Should we determine your insurance policy does cover all or a portion of the cost of therapy, your initial payment will be refunded or used as co- payment for future visits (Your preference)***

***4. I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.***

***5. I understand that I may pay for my sessions using a major credit card, personal check or cash at the time of service.***

***6. A credit card will be kept on file and updated at all times.***

**CONSENT FOR SERVICES**

Thank you for reviewing this information and please feel free to discuss any of this information with me. My/Our signature(s) on this disclosure statement indicates I/We have read and understood the conditions of the consultation services outlined. I/We have had the opportunity to clarify any questions and agree to the terms described above before receiving services. I/We have been provided with a copy of this disclosure statement.

## Credit Card Authorization Form

I, \_\_\_\_\_, am authorizing Heather D. Vest M.S., LPC, NCC to use my credit card information to charge my credit card for a scheduled therapy session, in the event that I do not notify the office of my inability to attend a scheduled therapy appointment, do not cancel my appointment at least 24 hours in advance, or a check is returned for any reason as agreed to in the Appointment and Professional Fees/Payment Arrangement policies stated in the signed Client Agreement and Therapeutic Policies Form that I have reviewed and signed.

Card Type (circle one): Visa MasterCard Discover Amex

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

Verification/Security Code (3 digit code on back of card by signature line): \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

By signing below I am authorizing *Heather D. Vest MS, LPC, NCC* to charge for scheduled appointments, no-shows, and late cancellations.

## Insurance Information

I, \_\_\_\_\_, am authorizing Heather D. Vest M.S., LPC, NCC to use my insurance information and communicate with my insurance company to figure eligibility and benefits. If the said policy covers mental health benefit, I understand the counselor will file claims of each session. I will be responsible for the co-pays/ deductibles and any expenses not covered by the plan according to the Appointment and Professional Fees/Payment Arrangement policies stated in the signed Client Agreement and Therapeutic Policies Form that I have reviewed and signed.

Name of Insured: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Member ID: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_

By signing below I am authorizing *Heather D. Vest MS, LPC, NCC* to use my insurance information and communicate with my insurance company for the purposes of payment.

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History of Present Problem/ Symptoms:

Psychiatric History/ Diagnosis:

Trauma History:

Family Psychiatric History:

Medical Conditions:

Substance Use:

Family History (Family of Origin):

Social Supports:

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Education/ Occupation:

Legal History:

Strengths/ Limitations: