



Informed Consent

CONFIDENTIALITY: Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required legally. _____ **Initial**

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law **when there is a reasonable suspicion of child, dependent, or elder abuse or neglect or where a patient presents a danger to self or others.** Disclosure may also be required by the courts. I will not release records to any third party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult patient. You will be informed before release is made. _____ **Initial**

EMERGENCY: If there is an emergency during therapy or after therapy, and I 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.

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HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: We recommend you not use insurance, however, if you choose to file, disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information is communicated to the carrier. _____ **Initial**

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for 5 years. As a patient, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any qualified medical personnel you specify. When more than one patient is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment. _____ **Initial**

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call. If I do not answer, I will return your call as soon as possible. If an emergency situation arises, call 911 or go to your nearest emergency room. _____ **Initial**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. You must be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we fully expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but sometimes it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I do not prescribe drugs.

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TREATMENT PLANS: On approximately your second visit, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask. You also have the right to ask about other treatments for your condition and their risks and benefits.

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TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept patients who, in my opinion, I cannot help. In that case, I will give you a referral whom you can contact. If at any point during therapy you are non-compliant, I will terminate treatment. In such a case, I will give you a licensed provider referral that may be of help to you. Upon your request, I will provide them with the essential information needed. You have the right to terminate therapy at any time.

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COURT TESTIMONY: Therapist is not trained in expert testimony. I agree not to involve therapist in court proceedings.

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DUTY TO WARN: Receiving counseling from a licensed professional is a confidential process. Your identity will not be revealed to anyone without your consent, **HOWEVER:** some courts have held that if a client intends to take harmful or dangerous action against another human being or against him/herself, a therapist has a Duty to Warn the intended victim and or state/local law enforcement. In cases of suspected child or elder abuse, I am required to notify appropriate state agencies. If you become involved in legal action, a court of law may subpoena my testimony or your records. I will, when expedient, notify you of these actions if they become necessary.

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SOCIAL NETWORKING AND INTERNET SEARCHES: I do not accept friend requests from current or former patients on social networking sites, such as Facebook. For this same reason, patients may not communicate with me via any interactive or social networking web sites.

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**Texas State Board of Examiners of Professional Counselors
512-834-6658
P.O Box 149347
Austin, TX 78714-9347**

I have read the above policies. I understand them and agree to comply.

Client's Signature _____ **Date** _____

Therapist's Signature _____ **Date** _____