The Shaunfield Counseling Center – Informed Consent

Please initial on the following:

_____**CONSENT FOR CARE AND TREATMENT:**

You may contact your counselor at the office number provided. However, due to my work schedule, I am often not immediately available by telephone. Please leave a voice message and I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your physician or the nearest emergency room.

1. We (I) agree to participate in the services provided by The Shaunfield Counseling Center and its associates in effort to resolve current issues or conflicts within my life or that of my family.
2. We (I) understand that the terms "therapist" "therapy" and "counselor" "counseling" may be used interchangeably in Shaunfield Counseling Center documents.
3. We (I) agree to support the therapeutic relationship with the counselor and to follow recommendations provided by the counselor, which might include referrals outside of this office.
4. Standard sessions are 45 – 50 minutes long.
5. We (I) understand that The Shaunfield Counseling Center associates do not provide medication of any kind.
6. We (I) understand that The Shaunfield Counseling Center's main focus is Mental Health Services and that it does not routinely provide court testimony.

_____**REQUEST FOR COURT APPEARANCE:**

If a therapist from The Shaunfield Counseling is subpoenaed to testify, the charge is $ 250.00 per hour including preparation time, travel time, testifying and any additional time away from the office. I understand and agree that I will pay a $1,500.00 retainer fee 72 hours prior to scheduled court appearance.

_____**REQUEST FOR RECORDS:**

- Requests for records must be made in writing with original signature. Request must be hand-delivered or delivered via Certified Mail.
- If a copy of client records is requested, there is a fee of $2.00 per page. Copy fees are due prior to release of records.
- Any letter or therapeutic summary is subject to a $75 per hour fee.
- Phone conferences with legal counsel are subject to a $75 per hour fee.

_____**CONFIDENTIALITY:**

I, the undersigned, have read and understand the confidentiality policy below.

Information shared with your counselor is confidential and will not be shared except for the reasons cited below:

- Suspected child abuse/neglect or abuse of disabled adults. The law requires that abuse be reported to the proper authorities in accordance with chapter 261.001 of the Texas Family Code.
- Client is a danger to himself/herself or others. Information will be disclosed to help protect persons from harm.
- Compliance with a court order.

_____**PRIVACY PRACTICE:**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law regulations. Upon request, we will provide you with the most recently revised notice on any office visit. I, the undersigned, have read and understand the Health Insurance Portability and Accountability Act ("HIPAA"). A copy is available upon request.

_____**ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:**

I, the undersigned, assign the payment of government /medical benefits to my counselor/ The Shaunfield Counseling Center. Also, I authorize The Shaunfield Counseling Center to release any medical information necessary to process claims for the services provided.

_____**FINANCIAL POLICY STATEMENT:**

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for all services rendered. I certify that all the information I have completed is true and correct to the best of my knowledge. I agree to notify you of any changes in status for the above information. I understand pre-certification by my EAP/insurance managed care company is not a guarantee of their payment. Final payment determination is made by insured's EAP/insurance at the time each claim is filed. Claims remaining unpaid by client's insurance for 90 days following the final session become client's responsibility.

_____**MULTIPLE PARTIES SHARING COST:**

I understand and agree that, in the case of more than one person sharing the cost, I am responsible for making all payments, including copays, punctually to The Shaunfield Counseling Center. It will be my responsibility to collect from the other parties involved. I am also responsible for sharing with the other parties all information regarding treatment and finances.

_____**CUSTODY DOCUMENTS:** I understand that I am responsible for presenting custody documents and keeping them updated, when applicable.

_____**RETURN CHECK POLICY:** There will be a $35 fee for each returned check.

_____**CANCELLATION POLICY:**

Clients who are unable to keep a scheduled appointment must cancel at least 24 hours in advance to prevent a **$75.00 LATE CANCELLATION FEE**. Monday appointments must be canceled by 5:00 p.m. the Friday prior to the appointment. This Late Cancellation Fee insures maximum appointment availability for you and other clients. I have read and understand the Cancellation Policy. I will take full responsibility of any penalties toward my actions.

I have read and understand the above information and accept FULL RESPONSIBILTY.

_____ _____

Employee/Client/Responsible Party Signature **Date**

_____

Printed Name of Responsible Party

_____ _____

Counselor **Date**