

## Denise Humphrey, Ph.D.

### AGREEMENT AND CONSENT FOR TREATMENT

A primary reason for attending therapy is to address the problem or problems that present difficulty, uncertainty, or perplexity, and that interfere with the more positive and productive life you want to live. A major goal in therapy is to identify those obstacles, examine the emotional patterns that affect thinking and acting, and explore how consistent those blueprints are. As human beings, whatever we focus on manifests as reality in our lives, although often the area of focus is unconscious. By making more parts of the unconscious mind conscious, we enhance our ability to understand our thinking and feelings, and introduce new choices in our lives.

It is important to begin therapy with an understanding of each of our rights and responsibilities, my office policies, fees, etc.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_ Do I have your permission to leave a message at  
this number? \_\_\_\_\_

If not, how may I contact you in case of an emergency or change of appointment?  
Please leave a number, if different from above: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Referred by \_\_\_\_\_

### CLIENTS RIGHTS AND RESPONSIBILITIES

Confidentiality: Trust and openness are essential for effective therapy, and I treat what you tell me with great care. My professional ethics and laws of this state prevent me from telling anyone else what you tell me unless you provide written permission. However, there are times when the law limits confidentiality and requires me to contact others. Situations when I am required to disclose information include:

1. If there is known or suspected abuse of a child, elder, or disabled person
2. If there is risk of imminent serious harm to you or others
3. If you are required to sign a release of confidential information by your medical insurance
4. If your records are subpoenaed by a court of law
5. If there is known or suspected sexual exploitation of a client by a therapist

Client initials: \_\_\_\_\_

There are situation in which limits of confidentiality are not mandated by legal sources, and include the following:

1. Clients being seen in couple, family and group therapy are obligated to respect the confidentiality of others. I will exercise discretion when disclosing private information to other participants in your treatment process (such as your spouse, other group members, etc.).
2. I may at times speak with professional colleagues about your case without asking permission, but your identity will be disguised.
3. Clients, under age 18 do not have full confidentiality from their parents.

Client initials: \_\_\_\_\_

Note on Payment: You will be expected to pay for each session at the time it is held unless we agree otherwise. I accept cash, checks, or credit cards (Visa, MC, Discover). I am not affiliated with any insurance or managed care companies. A fee will be charged for all returned checks.

Client initials: \_\_\_\_\_

Fees: The fee for service covers a 50-minute therapy session, including time for scheduling, payment, and therapy. Per session fee will be agreed upon in the first treatment session. Telephone calls may be charged at approximately the same rate as personal consultation and therapy.

Agreed Fee: \_\_\_\_\_

Client initials: \_\_\_\_\_

Note on Cancellations: Scheduled appointment times are reserved especially for you. If you are unable to keep your appointment, please contact me, via office phone, as soon as possible. Sessions canceled with less than 24-hour notice must be paid for in full. This is also true if you fail to notify me that you cannot attend an appointment. In case of failure to cancel a session, future standing appointment times will not be reserved or reinstated until payment is received for the missed session.

Client initials: \_\_\_\_\_

Establishing the Therapeutic Relationship: In order for therapy to be successful, it is important that both client and therapist feel the relationship is compatible. Therefore, the client and I will evaluate the therapeutic alliance on a regular basis and decide if the match appears to contain the conditions necessary for successful treatment. If the therapeutic alliance does not appear to be the best for you, I will provide referrals for other therapists and/or psychiatrists.

Client initials: \_\_\_\_\_

Personal Data: You are asked to provide me with your most current address and phone numbers at all times so that you may be reached in cases of scheduling, payment issues, or emergencies.

Client initials: \_\_\_\_\_

## **THERAPIST RIGHTS AND RESPONSIBILITIES**

It is my responsibility to provide you with informed, respectful, and competent care in accordance with the highest ethical and legal standards. I request the same safe, respectful treatment you can expect from me. I may also exercise the following rights:

Scheduling: I will make every attempt to keep our appointment times. However, emergencies and other urgent situations may arise that necessitate rescheduling your appointment. I will notify you as soon as possible in these situations. Dates of vacations and other exceptions will be provided in advance. Appointments for telephone sessions can be made by calling the office.

Client initials: \_\_\_\_\_

Consultation: I may seek consultation with other professional colleagues as needed in order to provide the most appropriate and effective services to you. Such consultation will not involve your name or specific information unless we have first discussed the need for this, and you have provided written permission to do so.

Client initials: \_\_\_\_\_

Termination of Treatment: If I feel that the services I can offer are not, or will not be appropriate for you, I may, after discussing reasons with you, refer you to another provider or agency. Furthermore, I reserve the right to terminate service if treatment recommendations are not followed. Such situations include: if payment is not timely, if recommended consultations are not sought, if medication is not taken as prescribed for mental health continuity, if dangerous practices are continued, or if sessions are attended after consuming drugs or alcohol.

Client initials: \_\_\_\_\_

Emergency Service: I do not generally provide after-hours emergency care. However, in an emergency, you may call the office and I will return the call if I am available. In the case of an emergency during which I cannot be reached, emergency services are available at the Parkland Hospital Psychiatric Emergency Room. The telephone number for the Parkland Hospital Psychiatric Emergency Room is 214-590-8761, or contact the Suicide & Crisis Center at 214-828-1000.

## **AGREEMENT FOR PSYCHOTHERAPY CONSULTATION AND TREATMENT**

I have read this informed consent completely and have raised any questions I might have. I have received full and satisfactory responses and agree to the provisions freely.

I understand that Dr. Humphrey is responsible for maintaining all professional standards set forth in the ethical principles of her professional association as well as the laws of the state of Texas governing the practice of psychotherapy.

I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with Dr. Humphrey.

The agreement constitutes the entirety of our professional contract. Both parties must sign any changes. I have a right to keep a copy of this contract.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

If applicable:

Legal Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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