AGREEMENT AND CONSENT FOR TREATMENT

Denise Humphrey, Ph.D.

Welcome to my practice. I am honored you have chosen me as your therapist and look forward to getting to know you. In order for our professional partnership to be most effective in meeting your needs and goals, it is important to begin with a clear understanding of expectations. 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. In order for the therapy to be most successful, you will have to work on things we talk about both during our session and at home. 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 situations 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 our 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 a health insurance provider for BCBS and MHN. A fee will be charged for all returned checks.

Client initials: _____

Fees: Full fee per session is $140 if you are not a member of BCBS or MHN. Copay is determined at the initial session. You may owe a copay or the full contracted fee as determined by your insurance plan. It is important to note that insurance companies do not provide reimbursement for cancelled or no show sessions.

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 via office phone as soon as possible. Sessions canceled within less than a 24-hour notice must be paid for in full. This is also true if you fail to notify me that you cannot attend the scheduled appointment and don't show up. If you are a member of either BCBS or MHN, you are required to pay the full fee if you either do not cancel your appointment more than 24 hours in advance, of if you do not show at your scheduled appointment without notifying me.

Client initials: _____

Forensic Agreement: I do not practice forensic psychology and do not conduct forensic evaluations. If you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation, report writing, copy costs, and transportation costs, even if I am called to testify by another party. Because of the complexity of legal involvement, I charge $300 per hour for preparation and attendance at any legal proceeding. A $600 retainer is required.

Client initials: _____

Establishing the Therapeutic Relationship: In order for therapy to be successful, it is important both client and therapist feel the relationship is comfortable. 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 emergences.
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: _____

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 mental health continuity, if dangerous practices are continued, or if sessions are attended after consuming drugs or alcohol.

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 and your are in need of immediate assistance, call the Suicide & Crisis Center at 214-828-1000, the Contact Counseling at 972-233-2233, or go to your nearest emergency room.**

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.

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 if requested.

Client Signature _____ Date _____

Print Name _____

Therapist Signature _____Date _____

If applicable:
Legal Parent or Guardian Signature _____ Date _____

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