

## INFORMED CONSENT/THERAPY AGREEMENT/PRIVACY POLICY

**Welcome!** This document answers many questions clients often ask about therapy and explains my procedures, expectations, and privacy policy. After reading and fully understanding its contents, you will be asked to initial each page and sign the therapy agreement. Please retain a copy for your records/reference.

### **SESSION FEES:**

Couple/Family: (60 minutes): **\$125**      Individual/Child (45 minutes): **\$110**

*All* professional time will be billed for at a rate of \$2 per minute. This includes writing or reading reports or letters on your behalf, scoring of rating scales/evaluations, consultation/phone calls, extended sessions, copying/mailing of records, off-site observations (including travel time), etc. While there is no charge for calls to schedule/change appointments, inquire about services, etc., after hours consultation calls are charged at 150% of the usual rate.

Your session time is for you and is taken seriously. You are contracting for the time you have scheduled. Please make every attempt to attend your scheduled sessions and arrive on time. **Twenty-four (24) hours notice is required in order to cancel an appointment.** To maintain consistency from one client to another and to maintain flexibility to be able to meet with clients in a timely manner, **exceptions will not be made.** If an appointment is not canceled 24 hours in advance, **you will be charged \$55 for the session.** This helps to eliminate “No Shows” and insures maximum appointment availability for you.

To be respectful of others who may be in session, please monitor children at all times remaining in the waiting area until you are called for your session. I value and honor my clients of all ages, *and* I value the time and expense which I have invested. You are accountable for any damage to, or removal of, property in the office by you or anyone for whom you are legally responsible as well as any personal property/valuables you choose to bring to the office.

### **PAYMENT:**

Payment in full for all professional services is due at the time of the service whenever face-to-face. You (or parent/guardian) are directly responsible for payment. **Checks should be made payable to: Tiffany Priska.** It is helpful to have checks made out before the session begins. Returned checks are subject to a **\$25** service fee which must be paid prior to the next appointment, and future payments will be required to be made with cash or money order. Because payment is due when services are rendered, I usually do not send bills. If, however, a situation necessitates that you be billed, please remit payment within five days of receiving the invoice. Should payment problems arise, they must be worked out openly and quickly. Such problems can greatly interfere with the therapy progress and our working relationship.

*Insurance:* Your health insurance policy is a contract between you and your insurance company. Should you choose not to use your insurance, you may be eligible for “out of network” benefits, but will need to research the extent of your coverage to make this determination. You are responsible for completing and filing the necessary paperwork for insurance reimbursement in such a situation. I will provide you a receipt for services rendered. Please let me know if you intend to access your insurance benefits as additional information, such as a specific diagnosis, is usually required. You are also responsible for keeping track of your benefit requirements/limitations such as the number of sessions allowed per calendar year, authorized time periods, and so on. Please be aware I have no control or responsibility for confidentiality procedures employed by your insurance company. Should you choose insurance as an option, I may be required to provide the company with your personal health information, which includes history as well as current status, for you to be reimbursed. You must give written permission for the release of your personal health information.

### **CONFIDENTIALITY:**

All information shared in session is held in strictest confidence according to federal regulations. The following are exceptions: 1) Legal obligation such as child or elder abuse, court subpoena, cooperating with law enforcement officers, etc., 2) Suspected personal danger to yourself or an identifiable victim, 3) Information required by insurance companies for payment (for which you consented), 4) Information provided to parents if the client is a

minor, 5) Valid collection of a debt, and/or 6) Consultation with other professionals in order to aid in the counseling/therapy process (identifying information will be withheld unless written permission is given). Release of information to other individuals, agencies, or professionals may only be done with your written consent.

**EMERGENCIES:**

For an emergency, please attempt to contact me by calling the office phone number (281-373-5200). If I cannot be reached immediately by phone, you, your family member, or friend should call the **HOUSTON CRISIS HOTLINE at 713-468-5463, DIAL 911, or GO/BE TAKEN TO THE NEAREST HOSPITAL EMERGENCY ROOM.**

**RECORDS:**

If, as part of therapy, you create and provide to me records, notes, artworks, or any other documents or materials, I will return the originals to you at your written request but will retain copies. You have the right to review or get copies of your personal health information with limited exceptions. You must submit a written request and allow a reasonable time period (maximum of 30 days) for compliance. If you are concerned that I have violated your privacy rights, or disagree with a decision I have made in regards to access to your personal health information, please inform me immediately. You also may submit a written complaint to the U.S. Department of Health and Human Services.

*Violations:* In my practice I follow the professional code of ethics of the American Counseling Association. Any violations of the Licensed Professional Counselor Act should be reported to: Texas State Board of Examiners of Professional Counselors, 1100 West 49<sup>th</sup> Street, Austin, TX 78756-3183, 512-834-6658.

**ABOUT THERAPY:**

Because you will be investing time, energy, and money into therapy, you should choose a therapist carefully. You should feel comfortable with the therapist you choose and hopeful about the therapy. When you feel this way, therapy is more likely to be very helpful to you. My work with clients focuses on wellness and increasing overall life satisfaction.

Utilizing a problem-solving/skill-building approach, we will work together to identify developmental and/or life issues and problems with which you may be dealing *and* useful skills to help you address your problems. We will devise a plan to help you incorporate your new skills into your daily living. You will be held responsible for your feelings and behavior while focusing on the identified “problem” rather than symptoms. Homework may be assigned which you will be asked to complete as a means of moving toward the achievement of your goals. Although no therapist/counselor can ethically guarantee achievement of goals, it has been my experience that the more you put into your therapy, the better the chance for positive results. You or I have the right to terminate therapy at any time. At least one session’s notice is helpful for all involved, should the decision to terminate therapy occur. This allows for closure. If needed, you will be provided the names and phone numbers of other qualified therapists.

*The Benefits and Risks of Therapy:* There may be some risks as well as many benefits with therapy. You should think about both the benefits and risks when making any treatment decisions. For example, in therapy there is a risk that you will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other such feelings. You may recall unpleasant memories which may bother you in settings outside of our sessions. You may receive feedback from some people who mistakenly suggest participating in therapy is a sign of weakness. (I believe investing in your personal growth is a sign of courage and strength!) Also, therapy has the potential to disturb relationships with people who are important to you – especially if family secrets are aired.

You may experience a temporary worsening of problems after beginning treatment, although this usually passes as you learn new skills and increase your self-confidence in applying them. Most of these risks are to be expected when making important changes in your life. Finally, even with our best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should also know the benefits of therapy have been scientifically researched and validated. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. In therapy, you will have a chance to talk things out fully until your feelings are relieved or your problems are solved. Your relationships and coping skills may improve greatly. You may get more satisfaction out of social

and family relationships. Your personal goals and values may become clearer. You may find yourself growing in many directions and experience an increased ability to fully enjoy your life.

*What to Expect from Our Relationship:* Therapy services are best provided in an atmosphere of trust. You expect me to be honest with you about your problems and progress, and I expect you to be honest with me about your expectations for services, your compliance with medical advice from your doctor, and any other treatment issues. As a Licensed Professional Counselor (LPC) I will use my best knowledge and skills to help you achieve your goals. My duty is to care for you and my other clients, but *only* in the professional role of therapist/counselor. Ethically, I am bound to avoid “dual relationships.” I am not able to advise you from other professional viewpoints such as law, medicine, finance, etc. I must honor confidentiality, excluding previously mentioned exceptions. To maintain privacy, I do not reveal the identities of my clients without their consent. Therefore, if we meet on the street, I may not say hello or talk to you very much. This would not be a personal reaction to you, but rather an effort to maintain the confidentiality of our relationship. Lastly, I cannot, now or ever, be a close friend, socialize, or have a romantic relationship with any of my clients, and cannot provide therapy to my family members or friends.

**AGREEMENT:**

I, \_\_\_\_\_, confirm that I have read, or have had read to me, in its entirety, this document. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the policies and procedures listed in this document. I understand that no specific promises have been made to me by Tiffany Priska, MA, LPC about the results of treatment, the effectiveness of the procedures used by her, or the number of sessions necessary for therapy to be effective. I understand that after therapy begins, I have the right to withdraw my consent at any time, for any reason. I will make every effort to discuss my concerns about my progress with Mrs. Priska before making the decision to end therapy.

I hereby agree to enter into therapy with Tiffany Priska, MA, LPC (or to have my minor child enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

\_\_\_\_\_  
Signature of Client (Parent/Guardian)

\_\_\_\_\_  
Date

Having met and discussed with this client (and/or client’s parent/guardian) the policies and procedures outlined in this document and having responded to all questions posed, I believe this person fully understands the information presented. I find no reason to believe this person is not fully competent and capable, legally or otherwise, to give informed consent for therapy. Therefore, I, Tiffany Priska, MA, LPC, agree to enter into a counseling/therapy relationship with this client as shown by my signature here.

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date