Client Name:_____

Client Agreement and Informed Consent for Treatment

Denette Mann, M.Ed., LPC-S, RPT-S, EMDR Certified

Welcome to my practice! I am honored that you have chosen me, and I look forward to getting to know you during this time of growth and possibility. The following information will help you understand the therapy process, each of our rights and responsibilities, and my office policies. Most of this disclosure is mandated by law for your information. If you have questions regarding any part of this document, please discuss them with me before signing this document.

Therapeutic Approach

I specialize in working with children, adolescents and related family matters. I am also trained in adult psychotherapy. My approach to psychotherapy is integrative and blends research-supported treatments including Gestalt therapy, interpersonal neurobiology, and mindfulness-based therapy. I strive to provide an atmosphere of support and trust to better enable individuals to overcome blockages to self-awareness and develop new ways of thinking, feeling, and behaving. The goals of psychotherapy treatment are not only to change behaviors currently causing concern, but also to understand the purpose and origins of such behaviors. I utilize therapeutic techniques specific to each person's individual needs including: play therapy, activity therapy, animal-assisted therapy, as well as traditional talk therapy. I am focused on supporting and encouraging my clients and myself towards wholeness in mind, body, and spirit.

Our office can be reached at 214.505.0745. Please contact me directly if you have any questions or concerns regarding the counseling you are receiving.

X _____ X _____

Client/Guardian Signature Date

Patient Rights and Responsibilities

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides for privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which accompanies this agreement, explains HIPAA and its application to your personal health information in detail. As required by law, on the last page of this agreement, you are asked for your signature acknowledging that you have been provided with this information. When you sign this document, it will represent an agreement between us.

Confidentiality

An atmosphere of trust and support is essential for effective therapy. However, there are some instances when the law limits confidentiality and requires us to contact others. There are also other urgent situations when I may choose to break confidentiality if doing so could help ensure the safety of you, others, or ourselves. I reserve the right to break confidentiality in the following circumstances:

1. If there is known or suspected abuse of a child, elderly person, or disabled person.
2. If there is risk of imminent serious harm to you or others.
3. If your records are subpoenaed by a court of law, or if I am subpoenaed to testify in court about our work together.
4. If there is known or suspected sexual exploitation of a patient by a current or former psychotherapist.
5. If you act aggressively, threateningly, or violently towards anyone in the therapist's office, including me.
6. In other situations, as described in my HIPAA Notice of Privacy Practices.

In any of these situations, only the information needed would be revealed. If I believe you are in danger of hurting yourself or others, I will contact any person in a position to prevent harm, including but not limited to the person listed as your emergency contact, family members, close friends, and appropriate medical and legal authorities.

Confidentiality and Health Care Collaboration: It is considered a standard of good practice for mental health professionals to collaborate with other members of a patient's healthcare team, including their primary care physician, psychiatrist, and others involved in providing regular care. Typically, I make contact with others on your treatment team to let them know we are working together and to inform them of our diagnostic impressions. After that, we may choose to communicate with them to coordinate your care, especially around issues including significant life or treatment transitions, responses or side effects to medication, physical symptoms, and risky behavior. Please provide this information as needed to allow us to collaborate with your healthcare team.

Evaluation and Feedback

During the therapy process, you are encouraged to provide feedback to me, discuss your goals, and review your progress. If you feel you are not making progress toward your goals or if you are dissatisfied with service, you agree to discuss these issues with me directly so that I may work together to decide the best way to proceed.

Potential Risks

In addition to the gains and positive outcomes associated with counseling and therapy, some "side effects" are possible. Because therapy involves examining interpersonal issues, you may: have difficulty concentrating, feel moodier, and experience some distress within relationships. Often, clients notice the increase in challenges/difficulties before they experience the positive outcomes of treatment.

As these issues arise, you agree to discuss them with me so that we can work to find ways to alleviate these difficulties.

Active Participation and Commitment

In order for counseling to be effective, it is important for you to take an active role. Active participation involves keeping appointments, being honest, discussing concerns openly, completing outside assignments, listening to the therapist, and providing feedback to your therapist about the process of counseling.

Use of Mind Altering Drugs or Alcohol

Do not appear for a session under the influence of any mind-altering drugs, including alcohol. Should the situation occur, the therapy session will not take place and you will be charged for the session. Such an occurrence may be considered grounds for termination of therapy.

**Please note: Firearms are strictly prohibited in my office suite. **

Technology Usage

Personal content exchanged through phone, text, or email may not be secure and can potentially be compromised. DM Psychotherapy Services is not liable for personal information that you choose to send via phone, text, or email should confidentiality be compromised. Email should only be used for scheduling or exchanging information pertaining to appointments.
I request children not use phones or other electronic devices 15 minutes prior to session, as it takes at least that long for the brain to return to be receptive to learning in our appointment.

Other Treatment Options

I strive to provide you the most effective care possible. However, it is important to be aware of other treatment options that are available. Different therapists may practice different approaches to therapy or have different areas of specialization that may be appropriate for you. In addition, some people can benefit from psychiatric care and medication. If you would like to explore different treatment options, please discuss this with me. In turn, I agree to talk with you about other treatment options I feel may be appropriate for you.

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. Dates of vacations and other exceptions will be provided in advance whenever possible. During times that I will be out of town or difficult to reach, I may ask another therapist to be on call for urgent situations.

When emergencies and other urgent situations arise for me that necessitate rescheduling your appointment, I will notify you as soon as possible. Every attempt will be made to reschedule your appointment at a time convenient for you. In the event of an emergency situation, my office will reach out to apprise you of the situation.

Consultation

Consulting with colleagues is a standard of mental health practice because it helps ensure that you receive good care. I may seek consultation with other professional colleagues as needed in order to provide the most appropriate and effective services to you. I am involved in a regular consultation group and may also seek input from other colleagues. These discussions will not involve your name or specific identifying information unless you have provided permission to do so.

Availability

I do not generally provide after-hours emergency care. It is not appropriate to call or send a lengthy email if you are feeling angry or upset and want to talk to someone, or to address routine office matters. **I do not read or respond to emails regarding matters outside of BRIEF scheduling matters.**

In an emergency, if I cannot be reached within a short period of time and you are in need of immediate assistance, call the Suicide and Crisis Center (214.828.1000) or Contact Counseling (972.233.2233), or go to your nearest emergency room.

In the unusual instance that we engage in an emergency after-hours phone consultation, you will be charged a fee proportionate to that of a regularly scheduled session. There is a minimum fee of $60.00 regardless of duration.

Records

Treatment Record: It is state law that I maintain a record of the treatment provided to you. This record will contain information that will allow us to chart the course of your therapy. Files are kept in a locked cabinet in a locked office suite.

*Please see the HIPAA Notice of Privacy Practices for information on how to request your records. *

Assessments: The materials used to administer, score and interpret psychological tests are not considered part of your record. Under copyright law they cannot be reproduced, and they can be released only to another qualified mental health professional under Texas law.

Group Sessions: If the therapy sessions contain more than one patient (e.g. couple's therapy), you agree that no one person may get the complete treatment file.

Maintenance of Records: The laws of this state require that entire patient records be kept for six (6) years. I will maintain records for that period of time. After this period, all records will be destroyed.

Possession of file by another mental health professional: In the event of therapist incapacitation or death, it will be necessary for another practitioner to take possession of your files and records. You agree to allow another licensed mental health professional, selected by me, to take possession of your file and contact you regarding this transition, providing treatment options and referrals if needed.

Termination of Treatment

Length of treatment: The length of time required for therapy will be determined by your personal situation. I will do my best to fulfill your therapeutic needs and provide you with the best therapeutic care. For your part, you agree to participate in the process to the best of your ability. It is intended that when your needs are met, to the extent they can be, we will terminate our relationship.

Client Termination: You may terminate services at any time. This may be done in several ways. These include, but are not limited to, putting it in writing or informing me verbally. If you choose to terminate therapy with me, it will be my decision as to whether we can re-establish our therapeutic relationship if you request to do so in the future.
In such circumstances, referrals to other therapists or agencies will be provided if requested.

Therapist Termination: A pattern of frequently canceled or missed appointments will result in termination.

Non-payment for services may result in termination.

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 dangerous/risky behaviors are continued or if sessions are attended after consuming drugs or alcohol.

Regardless of the reason for ending treatment, I ask that you allow yourself/your child to have 1-3 closure sessions.

HIPAA

The information about HIPAA included in this agreement, along with the Texas Notice Form describes your rights with regards to your Clinical Record and disclosures of protected health information. Your signature below serves as an acknowledgement that you have received the HIPAA notice.

X_____

Client/Guardian Printed Name

X_____ X _____

Client/Guardian Signature Date

Complaint Procedure:

If you are dissatisfied with any aspect of the counseling process, please inform my office so I can determine if our work together can be more efficient and effective or whether a referral would be appropriate. If you believe you have been treated unfairly or unethically, and I cannot resolve the problem, contact:

Texas State Board of Examiners of Professional Counselor Complaint Process
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
Or call 1-800-924-5540

Session and Fees:

Schedule of Fees	
Type of Service	**Fee**
Initial Consultation	$250.00
45 Minute (Individual) Session	$170.00
25 minute (Individual) Session	$90.00
90 Minute Session	$250.00
Additional Services- 1-30 minutes: $75.00 dollars 31-60 minutes: $150.00 Time therapist works outside of session on behalf of the client: 1. Talking to teachers/administration on behalf of your child 2. Consulting with a medical doctor, another psychologist or psychiatrist with whom you have given me permission to speak 3. Report writing 4. Scoring tests/reports 5. Contact between sessions via phone or text lasting more than 15 minutes between sessions	
Services Related to Legal Proceedings	$400/hour
Court Appearance/Testimony	$2,000/day

Payment is due at the time of services. I accept cash, check, or credit card. A $50-dollar fee will be charged for all returned checks It is your responsibility to provide my office with your most current contact/billing information at all times.

First Session: In order for therapy to work best, it is important that both the therapist and patient feel comfortable with each other. Our initial session is an intake assessment lasting 60-90 minutes. During this time, I want to find out more about your concerns and goals for treatment in order to determine if our skills and experience are a good match for what you need help with. This initial session is also an opportunity for you to determine if our approach feels like a good match for you. A therapeutic relationship will not officially be established until after we have discussed your presenting problems and we agree to work together on your goals for therapy.

Weekly Sessions: After the initial visit, sessions are typically at least once a week for 45-50 minutes, which includes time for scheduling, payment, and therapy. Our fee schedule will be discussed at the time you set your intake appointment with my office manager.

Half Sessions: In general, I do not offer 30-minute psychotherapy sessions. The only exception to this is in the case of younger children, who may only be appropriate for half sessions. This decision is on a case-by-case basis depending on the need.

Phone Sessions: In some cases, when an appointment can only be held remotely, we may agree on a *scheduled* video or phone session.

Late Cancelations or No Shows: I respectfully request 24 hours' notice when canceling an appointment so that I may offer the time to someone on my wait-list. My hourly rate is charged as a cancelation fee for missed appointments or cancelations made less than 24 hours from the scheduled time as well as for late shows (more than 10 minutes late).

Overdue Accounts: Accounts are considered delinquent after 30 days of non-payment. If an account reaches $150 of unpaid charges, routine visits will be discontinued until the entire account is paid. Delinquent accounts that go unpaid for more than 90 days will be turned over to a collection agency, with a surcharge of 30% added. Clients will be given 30 days' notice before the account is turned over to a collection agency.

Legal Fees: I am not a legal consultant or representative. I do not practice forensic psychology and do not conduct forensic evaluations. I do not make recommendations regarding custody agreements. I provide counseling, consultation, and psychotherapy to children and parents. Because I am mandated to protect the confidentiality of you and your child, I will not discuss the content of sessions with any legal representative unless I am subpoenaed to do so or ordered to do so by a presiding judge. If legal proceedings require my participation:

- You will be expected to pay for **all related time and expenses,** including preparation, report writing, copy costs, professional consultation, transportation, time needed to reschedule patient appointments and other professional meetings, as well as the entire time spent away from my office. This applies even if I am called to testify by another party.

- Due to the difficulties involved in legal matters, I charge **$300.00/hour with a minimum engagement of five hours to be paid as an advance retainer of $1500.**
- Additionally, for any legal proceedings that require us to be away from the office, I require **at least 72-hours advance notice** due to the time needed to reschedule patient appointments.
- In the event that my participation in legal proceedings has been scheduled but needs to be canceled, I require at least 48-hours' notice. Failure to provide at least 48-hours' notice of cancellation will result in your forfeiture of the retainer fee.

X_____

Client/Guardian Printed Name

X_____ X _____

Client/Guardian Signature Date

Office Cancellation Policy

I see clients by appointment. Once you have secured a time slot, it is reserved for you. No other person is able to book that appointment time. Because of this:

- This office requires 24 hours' notice when canceling an appointment. You will be charged a cancellation fee (equal to the current session fee) for missed appointments or cancellations made less than 24 hours from the scheduled time.
- I reserve the right to terminate treatment if you cancel 3 sessions in less than 24 hours before the appointment time.

Thank you for your consideration regarding this important matter.

We have discussed DMPS, PLLC appointment cancellation policy. Your signature below serves as your agreement to the terms above.

X Client/Guardian Signature: _____

X Date: _____

Consent to Policies and Procedures

Your signature below indicates that you have read this agreement and agree to its terms. Upon signing this agreement, you are choosing to enter into a professional relationship with me at DM Psychotherapy Services.

X_____

Client/Guardian Printed Name

X _____ X _____

Client/Guardian Signature Date