The Mindful Life Company
CONSULTATION AND COUNSELING

Informed Consent, Treatment Agreement, and Office Policies for Child/Adolescent Therapy

Welcome to my practice! This document contains important information about my professional services and business policies. Please read it carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us. Please read, initial on indicated spaces, and sign this document.

Psychotherapy Defined:

There are many different approaches to therapy, and as a therapist, I am not here to provide you or your child with advice but rather to walk alongside you during your unique process to reach your personal goals. A therapist helps clients with mental, emotional, cognitive, and behavioral difficulties, and counseling is intended to help you reach a better understanding of specific problems or increased self-awareness. It is also intended to work toward improvement of the identified problems, offer support with problem-solving, aid in some symptom relief, and foster improvement in coping with daily life activities. Your progress in counseling and its outcome depends upon multiple factors including, but not limited to, your level of motivation and desire to change, the effort that you put forth in following through with agreed upon therapeutic tasks outside of session, keeping your appointments, and your willingness to be open with me as we work together.

Within the therapeutic process, I conceptualize counseling from both an individual and systems perspective. That is, I can view your concerns through an individual perspective as well as looking at a wider perspective to include the interrelated experiences that are influencing and influenced by other member(s) of your relationship or family. Within this general framework, I generally take a humanistic or holistic approach to counseling and integrate techniques from multiple theoretical approaches to suit your particular presenting issues and concerns. I tend to work through a holistic approach which provides support that looks at the whole person rather than merely parts of mental health concerns or illnesses. I view counseling as a collaborative task, in which you take an active role in working toward your goals, both within and between sessions.

Potential Risks and Benefits (What to possibly expect):

Therapy may have both risks and benefits. Although you and your child will have a safe space within the counseling room, therapy often involves discussing difficult or unpleasant aspects of your lives, and you may experience uncomfortable reactions and emotions about these discussions, such as sadness, guilt, anger, frustration, and confusion. It is possible for a client's problems to worsen immediately after beginning therapy before they begin to get better. Moreover, some of the insight gained and changes you make as a result of counseling may not be welcomed by other people in your life. This may result in some strain in your relationships with family and friends, or and may disrupt a romantic relationship. Most of these risks are to be expected when people are making important changes or adjustments in their lives.

However, research shows therapy may also be beneficial and may also lead to improvements in individual mental and emotional health, communication and problem-solving skills, and increased positive coping and relationship satisfaction. It is crucial to understand that there are no guarantees about what you may experience during the process or how the therapeutic process may affect you. As a therapist, I will tailor strategies, methods, and interventions, with your agreement, to your unique concerns to work towards your family's personal goals.

Therapeutic Process (What therapy will look like):

Initial Assessment. Our first sessions, and possibly first few sessions will involve an assessment you and your child's therapy needs and goals. There are various outcomes of this initial assessment, and furthermore, an opportunity for us to decide if working together may be beneficial for you and your child. If my therapeutic approach appears to align and fit with your individual goals, I will offer you some first impressions of what our work will include if you decide to continue with therapy. I encouraged you to weigh this information, as well as your own opinions of whether you feel comfortable working with me, in deciding whether to continue with therapy. If you have any arising questions about my procedures during the initial assessment, or even at any point in subsequent treatment, please bring them to my attention.

Therapy involves a large commitment of time, money, and energy, so you should be selective with the therapist you choose. If you decide to continue with treatment, we will then move towards scheduling therapy sessions. Following our initial assessment, if you believe you would be more comfortable working with another mental health provider or believe that another mental health provider may be better suited to assist you and your child with your specific concerns, I will be happy to provide you referrals.

Counseling Sessions and Attendance: When an appointment hour is scheduled (45-55 minutes in duration for one session), you will be expected to pay for the session at the time of appointment, unless you provide 24 hours advance notice of cancellation, except in the case of a personal emergency. If you determine more than 24 hours in advance that you may be unable to attend, please contact me so that you can schedule a different time.

Together, we will typically agree on specific goals for therapy, such as reduction of symptoms, behavioral changes, improved communication and/or interpersonal skills, and I will prepare a treatment plan to guide our therapy. Goals will likely evolve as the therapy progresses and should be renegotiated accordingly. The therapeutic approach used will vary, and any questions or concerns should be discussed with me.

How long you and your child remain in therapy and the frequency of sessions is a matter best discussed while we work together to achieve your goals. While it is your right to end therapy at any time when you decide to end treatment it is in your best interest to discuss this with me beforehand.

Parents. If you are a parent, your participation in your child's counseling is important for long-term gains. You may need to learn a different way of working with your child to facilitate and maintain gains. I will ask for your feedback and views on your (your child's) therapy, progress, and other aspects of the therapy, and I will expect you to respond openly and honestly.

Minors. When working with minor clients I will initially meet with all involved parents or caregivers before meeting with the client. From that point forward all discussions about clinical matters and concerns about the client will be done in the presence of the minor unless specifically stated or instructed; meetings without the client present tend to undermine the trust and therapeutic relationship. How frequently caregivers attend is something that can be negotiated at the outset of treatment and can be adjusted as needed. I also ask that none of the adults should ask to speak with me before the child's appointment in front of the child. If you have information to share, please do it privately.

For minor clients who are between 16-17 years of age, it is my policy to request an agreement from the client and his/her parents that the parents' consent to forego their access to their child's records. If they agree, during treatment, I will provide parents only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's consent unless I feel that the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

In my practice, if the parents of the child client have remarried or have significant others who may be involved in the child's therapy, I like to meet with all the adults before seeing the child to obtain signed Authorizations for the limited sharing of information regarding the child and to establish the boundaries for my treatment of the child. Also, I do not allow stepparents to make therapy appointments for child clients unless the child's parents have signed an Authorization allowing the step-parent to schedule the child's appointments.

Additionally, only legally authorized representatives may sign this document, give consent to treatment, and acknowledge the privacy notice for another person. "Legally Authorized Representatives" are legal guardians/conservators of a minor, or a court-approved guardian or representative of a non-minor. If you are a parent or guardian who is consenting to treatment for a minor, by signing this Agreement, you affirm that you are the parent or legal guardian of the child; that you have the legal right to consent to psychological treatment for the child; that there has not been a Divorce Decree or any other Court Order that limits your ability to consent to the child's treatment. If the child's parents are divorced or never married, it is my practice to require BOTH parents to consent to treatment, in compliance with any Divorce Decree or Court Order that may be in place. I will also require a copy of the Divorce Decree or Court Order prior to providing any services to the child, and by your signature below, you agree to provide it immediately upon request; This must happen before I will see the child and I will need some time to review the documents.

Termination of Treatment. Following our work, I hope we will mutually agree about when you and your child have met your treatment goals, so we can schedule final sessions to review your progress and develop a plan to help protect you and your relationships from future distress. However, there are a few instances in which I may terminate our work together before reaching that point. If I believe that my approach and training is no longer appropriate for your specific concerns, or that either of you are not benefitting from treatment, I will inform you that I can no longer provide services and give you referrals to other mental health professionals who may be better suited to meet your needs.

I understand that any termination may be difficult, but my decision on this matter will be final. If you request and authorize it in writing, I will confer with your new therapist to help with the transition. Upon termination of therapy for any reason, the termination will be confirmed in writing.

Note: If you choose to involve the legal system in our work together by issuing a subpoena for my treatment records or my testimony in court, this will represent a conflict of interest for me, and I will terminate our therapeutic relationship and provide referrals to other providers. See more information in within the *Litigation and Court Policies.*

In addition, if you schedule a session and do not attend the session or call me within 7 days of that appointment, I will understand that as a termination in our services. If you wish to resume services after this occurs, please contact me.

Limits of confidentiality:

In general, the privacy of all communication between you and your therapist is protected by law, and I can only release information about our work to others outside the relationship with your written permission. There are a few exceptions to this which include:

1. If I believe that you are in danger of harming yourself or another
2. If you disclose information that leads me to suspect that a minor, elderly, or disabled person is being abused or neglected, I am required by law to notify authorities within 48 hours and I will comply with this requirement.
3. If a court order or other legal proceeding or statute, or investigation by a municipal, state, or federal agency requires disclosure of your information, I will obey the court order or the law.
4. If you file a lawsuit or a complaint against me for any reason related to your therapy, I am allowed to use confidential information to defend myself.
5. If you waive the rights to privilege or give written authorization to disclose information, I will comply with your authorization.
6. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy. I will not use these methods of communication for clinical information, but if you choose to do so privacy could be compromised.

Note: For best quality care and per my ethical duties, I will often consult with qualified Mental Health professions and discuss concerns needing further clinical assessment shall they arise. For more information on your rights and laws regarding your protected health information (PHI), please see the Confidentiality and HIPPA Notice of Privacy Policy.

Professional Fees, Billing, and Payments:

My hourly fee for an initial session is $125.00, the fee for a 60-minute therapy session is $125.00, and the fee for a single 45-minute therapy session is $100.00. In addition to therapy appointments, I may charge my $100.00 hourly fee for other professional services you may request, although I will pro-rate the hourly cost if I work for periods of less than one hour. It should be understood, if you request these OTHER services, they will not be covered by your insurance or benefit provider and will be your responsibility to pay out of pocket. Other services may include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of

me. The hourly fee is standard unless other arrangements with insurance providers or Employee Assistance Programs (EAP) have been processed and approved.

Payment for psychotherapy is due before or at the time services are rendered. Payment is accepted in the form of a credit card, cash, or check; note a $30 fee is charged for each returned check. Unless it has been prearranged, services may not be provided as scheduled if the client has an outstanding balance. To avoid an accumulation of a balance, clients are encouraged to complete a Billing Agreement and to provide credit card information to remain on file during the time they are active clients. Credit cards will only be billed for services provided, returned check fees, or no-show/late cancellation charges. Credit card information is securely destroyed 60 days after your last session or immediately upon your communication that you are terminating the therapeutic relationship.

You (not your insurance company) are responsible for the full payment of fees. You are responsible for knowing what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administration. I can provide a weekly bill or monthly superbill for submission to your insurance provider. However, you (not your insurance company) are responsible for full payment of all fees. You are responsible for knowing what mental health services your insurance policy covers. If you have questions about the coverage, please contact your plan administration. **Note:** I am not a provider for Medicare or Medicaid and I will not be able to bill either of these insurance providers.

Most insurance companies require a clinical diagnosis to reimburse for treatment. Some may require additional clinical information to support payment. Information collected by an insurance company will become part of the company's files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. Medical data has been also reported to be legally accessed by enforcement and other agencies, which may place you in a vulnerable position. The safest way to protect confidentiality is to pay cash for treatment.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

Cancellation and No-Show Policy:

It is important that my clients understand that I am in solo-private practice and when an appointment is canceled too late to find a replacement, I incur a substantial loss of income. To maintain a stable private practice, I charge fees for appointments that are missed or canceled too close to the appointment time; It should be understood that these fees are not meant to be punitive in nature but are designed to moderately compensate me for loss of time.

By initialing and signing this document, you are agreeing to pay a $35 fee for any appointment canceled within 24 hours of the appointment time. You agree to pay $65 for any appointment missed without a notification before the scheduled appointment time. You agree that these are reasonable fees to compensate me for the time lost regardless of the reason for the cancelation or missed appointment, that these fees cannot be billed to your insurance, and that you are solely responsible and agree to pay

these fees out-of-pocket (personally). It is understood that there will be NO fee charged for appointments canceled prior to 24 hours from the appointment time.

Professional Records:

Texas law requires that I maintain appropriate treatment records for at least 5 years from the last date of service. If the client is a minor child, I must maintain treatment records for 5 years from the date the child turns 18. As a client, You have the right to review or receive a summary of your child's records at any time, except in limited legal circumstances or situations when such release might be harmful to you or others. In

will provide them to you within 15 days of receiving the request unless I believe that I must withhold the records due to a situation involving life endangerment. In that case, I will write you a letter to explain my reasons for withholding the records and your options.

All requests for records must be made in writing and fees for the copying of records provided will be charged at a minimum of $25.00 for the first 10 pages, and then $.20 cents per page for each page thereafter. Additionally, I am not required to provide copies of requested records until the fee is paid, and minimum advance notice of one week.

Litigation Policy and Court-Related Services:

If you are seeking services for a minor that is involved in a suit affecting the parent-child relationship (example: custody, divorce, guardianship, parental rights), please be aware that I provide strictly therapeutic services. I am not a forensic evaluator or parent coordinator, and I do not offer case studies, parent fitness evaluations, access to or visitation with minor children, home studies, or legal advice as these are outside of my scope of practice. I do not want to be involved in your litigation nor do I want to deal with subpoenas or lawyers. The nature of the therapeutic process often involves making a full disclosure regarding many matters which may be extremely private, upsetting or possibly embarrassing. Furthermore, I do not enjoy having to disclose your confidential information in court nor do I want to deal with the negative feelings that can result from court or deposition testimony. If I am subpoenaed for testimony in a legal proceeding related to custody, please understand that it will be detrimental to the therapeutic relationship and I will in most cases be ethically obligated to terminate services.

If you involve me in your litigation, or if you or your attorneys subpoena me to provide my records, testify in court or give a deposition in violation of this agreement and against my stated wishes, I will comply with lawfully issued subpoenas. If I am subpoenaed to provide records or testimony in violation of this agreement and against my stated wishes, you also acknowledge and agree that you will pay for all of my professional time, including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, and time spent testifying in court or deposition regardless of who issues the subpoena or requires me to testify.

My hourly charge for all time related to court cases or litigation within the county I practice is $300.00 for a minimum of 4 hours ($1,200); If I am required to testify in court or give a deposition outside of the county in which I practice, the hourly fee will be $300.00 for a minimum of 6 hours ($1,800). If I am subpoenaed and the case is reset with less than 72-hour notice prior to the beginning of the day of the scheduled subpoena, trial, and/or testimony, there will be a $500 fee associated with the cancelation of

any scheduled clients. Any remaining costs associated with the legal actions will be invoiced as soon as the proceedings are completed and will be applied to the client's account balance. You also agree by your signature below to execute and sign a Credit Card Authorization and provide a valid credit card to ensure payment for the time I must spend dealing with your litigation.

All payments are due 2-business-days prior to the scheduled court appearance or deposition (note: if the court hearing/deposition is scheduled for a Monday at 12 noon, payment is due no later than 12 noon on Thursday). When I go to court or give a deposition, I must clear my schedule and not see other clients, so there is a 2-business-day cancelation policy for court and depositions. For example, if the court appearance or deposition is scheduled for 12pm on Monday, I must be notified of any cancelation no later than 12pm on Thursday before. Any cancelations that occur within the 2-business-day time frame of the court appearance or deposition are NON-REFUNDABLE and you will be charged the full minimum cost as described above.

I will accept cash, money order, cashier's check, or credit cards for payment of time related to court appearances or deposition. NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES. All payments are due 2-business-days prior to the scheduled court appearance or deposition, and (note: Monday court hearing/deposition payment due no later than 12:00 Noon on Thursday). By initialing and your signature below, you expressly authorize me to run these charges to the credit card on file in my office unless you notify me that you intend to make payment by cash, money order or cashier's check.

Communication Policy:

Other than session attendance, the only way I may be contacted is by office phone (254-290-8755). My office hours vary, and I am often not immediately available by telephone, but I routinely return calls within 24-48 hours during regular business hours, Monday through Friday, 9:00 a.m. to 5:00 p.m. Phone messages are answered during office hours often in between sessions and are often kept to a minimum of 5 to minutes in an effort to provide timely responses to all of my clients. If you require a longer conversation, please schedule a Phone Consultation with me during office hours. Phone Consultation Costs scheduled during regular practice hours are billed at a rate of $100/hour in 15 minute increments. After-hours are subject to an additional $50 surcharge unless previously agreed within the contract for services.

If you experience a life-threatening emergency, and I am not available by telephone, you should go immediately to the nearest hospital emergency room and request to see a mental health professional. Another option is to call 911.

If you are suicidal you can call:
The Suicide Prevention Lifeline

- Call: 800-273-8255 (800-273-TALK)
- Chat online: www.suicidepreventionlifeline.org
- Support for people who are deaf and hard of hearing: 800-799-4889
- La Red Nacional de Prevención del Suicidio: 888-628-9454

If you have insurance, you can call the number listed on the back of your card and get a referral to an in-network psychiatric hospital for consultation with an intake specialist.

Email. I do not use e-mail or text messages with clients regarding clinical matters. If your concerns are you need to discuss a clinical matter between sessions, please call me. If you choose not to respect my policy regarding e-mail and text communications, I will take steps to block further electronic communications. I also reserve the right to terminate therapy and refer you to other providers. Any e-mails you send to me may be printed and will become part of your clinical record. However, parents will have the option of messaging me within the secure messaging system to inform me of any concerns.

Texting. I prefer to not text with clients. All clients should contact me by telephone for any substantive matter relating to their therapy; Use of e-mail is utilized for administrative purposes.

Social Media. I do not engage in communication or relationships via social media with clients. This is for the protection of your privacy as well as our therapeutic relationship. If you happen to encounter me by accident through social media or the internet, please feel free to discuss this with me in session. I do not accept "friend" requests from current or former clients on my counseling related profiles on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites. I believe that you have violated this agreement, I reserve the right to terminate our professional relationship immediately and refer you to other mental health professionals.

Interactions Outside the Office. If we happen to encounter each other outside of the professional setting I will not address you unless you address me first. This is also for the protection of your privacy from those either of us may be with. I'm happy to return a friendly greeting but will allow you to take the initiative if you would prefer to do so.

Note: I do not allow audiotaping of sessions unless we have agreed otherwise in advance, and you have signed a specific written authorization for the taping to occur.

Complaints and Grievances:

If you are unsatisfied with my services or therapeutic approach, please feel free to bring those concerns to my attention. I welcome your feedback. Together we can assess the situation and determine if we can proceed or if another therapist may be better equipped to help you. If we cannot work things out to your satisfaction you may inform your insurance carrier and file a complaint with them or with my licensing board. The Texas Behavioral Health Executive Council (BHEC) investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Texas Behavioral Health Executive Council 333 Guadalupe St., Ste. 3-900
Austin, Texas 78701
Tel. (512) 305-7700 ; 1-800-821-3205 24-hour, toll-free complaint system
https://www.bhec.texas.gov/texas-state-board-of-examiners-of-professional-counselors/index.html

If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

I am electing to pay for services using: (choose only one by initial)

_____ Private Pay – Do NOT bill insurance, I want to pay privately (out-of-pocket), and understand that my therapist will NOT submit claims on my behalf for services rendered. I understand that if in the future I decide that I would like claims submitted on my behalf, I will supply insurance information to my therapist and that will constitute an authorization to bill insurance for future sessions. I understand that my therapist will NOT retroactively bill insurance, and no dates of service will be billed to a benefit provider until that provider has been verified which may take up to 2 business days from the date I supply the information. If I have insurance benefits, I am electing NOT to use them. I agree that I will not pay my therapist privately for services and then at any time bill an insurance company for those same services, this practice is known as balance-billing and is not allowed under the terms of this agreement.

I understand that if I wish to change how I want to pay for services that I must supply up to date information on my benefit provider and allow 2 business days for that information to be verified and uploaded into my therapists billing system. When I supply such information that will constitute an authorization to begin billing for all applicable services after the information has been verified. I understand that no services will be billed to my benefit provider until the information is verified, and past services will NOT retroactively be billed to my benefit provider. I understand that if my benefits change and the information I have supplied is out of date I will be billed at the private pay rates stated above until such time as I provide updated insurance information, and that information has been verified.

_____ Insurance or EAP benefits - Please write the name of Insurance you want to use: _____. I am instructing my therapist to bill my benefit provider. I have supplied my correct insurance information to my therapist.

Further Consents:

Permission for Coordination of Care: By initialing here I authorize my Mindful Life Company therapist to send a coordination of care letter to my doctor or PCP. I further authorize my therapist to send information to my doctor if there is a clinical need for coordination of care. This information may include notes, records, lists of appointments, letters, and/or any other information pertaining to my therapy.

Name of Doctor/PCP: _____
Hospital or Clinic:_____ City & State:_____
Doctor's Phone Number (if known): _____
Doctor's Fax Number (if known):_____

Emergency Contact: I give my permission and consent for my therapist to contact the person listed below in case of emergency. I give my consent for my therapist to provide this person with as much information as needed to avoid a dangerous or potentially life-threatening emergency.

Emergency Contact Name: _____ Phone #: _____
Relation: _____

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS:

_____ I have read and understand the purpose of psychotherapy, the potential risks and benefits of therapy, and my obligations within the therapeutic process.

_____I understand that The Mindful Life Company, PLLC cannot guarantee any particular results or outcome from the psychotherapy process and the

_____I understand and agree to the confidentiality policies stated above. These include the exceptions to confidentiality as mandated by state law.

_____I agree to give 24-hour notice for cancelled appointments if at all possible by calling the practice directly at (254) 290-8577 or emailing the practice email (kia.g@mindfullifeco.com). I understand that failure to cancel or reschedule an appointment with less than 24 hours' notice (late cancellation) is subject to the $35 fee, and I understand that failure to notify and no-showing is subject to a $65 fee.

_____I understand that The Mindful Life Company, PLLC does not provide emergency services and in the event of an emergency life-threatening issue, I agree to go to the nearest emergency room, and/or call 9-1-1 if an emergency were to occur.

_____I agree to pay the fees, including late/no-show fees, phone consultations and legal fees, as stated in this informed consent and contract for treatment with The Mindful Life Company, PLLC.

_____By initialing here and signing below you are attesting that you are a legally authorized representative and have legal rights to give consent and make medical decisions for the client. By initialing you are attesting that if you have been ordered by a court to notify the other parent of medical and/or behavioral health services, you have done so.

_____I are entering therapy by choice and understand that I/we have the right to end treatment at any time, and I understand this informed consent is voluntary and will become effective immediately and can be withdrawn at any time.

- I have read this information fully and have discussed any questions about the information presented with my therapist.

_____

Printed name of Client

_____

Signature of Client

_____

Date signed