Informed Consent for Counseling and Psychotherapy

Mental Health Services

West Texas Counseling and Guidance (WTCG) recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move toward resolving your difficulties. The therapist will strive to help you grow toward greater health and wholeness by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our therapists work within the context of each individual’s beliefs, and no attempt is made to impose a personal theology.

Therapist

The therapist is a licensed professional engaged in providing mental health care services to clients directly as an employee of WTCG. The therapist has discussed with me the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. You may withdraw from treatment at any time, but please discuss this with your therapist.

Appointments and Cancellations

Appointments are made by calling 325-944-2561, Monday through Friday between the hours of 8:00 am and 5:00 pm. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. Medicaid clients are not charged a fee per the law. Clients who repeatedly miss appointments may be discharged from services (see the No Show & Cancellation Policy form). Your therapist reserves the right to cancel your appointment if you show up sick or with minor children that might interfere with the counseling session.

Number and Length of Sessions

The number of sessions needed depends on many factors and will be discussed by the therapist. The length of therapy sessions range depending on several factors, and the therapist will discuss this with you.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your
friend or to have a social and personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

**Goals, Purposes, and Techniques of Therapy**

There may be multiple interventions to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting goals of your therapy. As therapy progresses, these may change.

**Confidentiality**

Discussions between a therapist and a client are confidential. No information will be released without the client’s written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist’s judgment, it is necessary to warn, notify, or disclose; fee disputes between therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority.

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing the Receipt form for the Informed Consent and Privacy Practices, you are giving your consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

**Duty to Warn**

In the event that the therapist reasonably believes that the client is a danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.

By signing Informed Consent and Privacy Practices form, you acknowledged that you have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices section of this form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of
your protected health information by the authorized recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

**Risks of Therapy**

Therapy is the Greek word for *change*. Clients often learn things about themselves that they don’t like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

**Payment for Services**

The charge for your initial one-hour session (53 minutes with therapist) is $108.00 and the charge for any subsequent one-hour (53 minute) session is $104.00. Shorter sessions will be a percentage of the full fee. **WTCG will look to you for full payment of your account, and you will be responsible for payment of all charges.** If you have insurance, different copayments are required by various group coverage plans. Your copayment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the copayment may be different for the first visit than for subsequent visits. You are responsible for and shall pay your copay portion of the therapist’s charges for the services at the time services are provided. **You are responsible for notifying WTCG immediately of any changes to your insurance.** If you fail to notify WTCG of any changes to insurance, you may be billed for services that are not covered.

**Court**

Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or the therapist’s testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist’s normal hourly rate of $104.00 for giving that testimony. Such payments are to be made at the time prior to the time the services are rendered by the therapist. The therapist may require a deposit for anticipated court appearances and preparation.

**After-Hour Emergencies**

A mental health professional is on call when WTCG is closed and can be reached for emergencies on a 24-hour, seven-days-per-week basis, by calling 325-653-5933. Emergencies are urgent issues requiring immediate action.
Therapist’s Incapacity or Death

In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing the Informed Consent and Privacy Practices Receipt, you give your consent to another licensed mental health professional at West Texas Counseling and Guidance to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

Consent to Treatment

By signing the Informed Consent and Privacy Practices Receipt, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time. By signing the Informed Consent and Privacy Practices Receipt, you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

Contact Information

By signing the Informed Consent and Privacy Practices Receipt, you are consenting for WTCG to communicate with you by mail, e-mail, and phone at the address and phone numbers provided at the initial appointment, and you will immediately advise WTCG in the event of any change. You agree to notify the Center if you need to opt out of any form of communication.
Notice of the West Texas Counseling and Guidance Privacy Practices

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the state of Texas to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. This notice took effect on April 14, 2003 and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at West Texas Counseling and Guidance. These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance, which we will provide at no charge to you. Here are some examples of how we use and disclose information about your health information. We may use or disclose your health information...

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center’s operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.
7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that is necessary to respond to the emergency.

8. To the appropriate State agency if, we suspect the neglect or abuse of a minor or adult. If, in our professional judgment, we believe that a patient is threatening serious harm to another, we are required to take protective action, which may include notifying the police, or seeking the client’s hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization.

We will not use your health information in any of our Center’s marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of the West Texas Counseling and Guidance, you have these important rights:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.
B. You can ask us for photocopies of the information in part “A” above. There will be a $5.00 charge for copies made here at the Center. If you need copies of your health information due to a Third party request, we will charge a fee of $25.00 for the first 10 pages, then $1.00 for each additional page.
D. You have a right to a copy of this notice at no charge.
E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if you request that we contact you on an alternative phone number other than your residence, or if your primary language is not spoken at this Center ) Your written request must specify the alternative means and location.
F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
G. You can make a written request that we amend the information in part “A” above.
H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.
I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.
J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than
treatment, payment, or our Center’s operations. This can go back as far as six years, but not before April 14, 2003.

K. If you request the accounting in “J” above more than once in a 12-month period we may charge you a fee based on our actual costs of tabulating these disclosures.

L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person: Dustin McCoy, Compliance Officer, 242 N. Magdalen Street, San Angelo, TX 76903. Telephone: 325-944-2561 | Fax: 325-653-4218.

M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.
RECEIPT: West Texas Counseling & Guidance

I, ____________________________ acknowledge that I have received signed copies of the Informed Consent and Privacy Practices forms from my therapist/my child’s therapist on this date ____________________.

If signing for a minor child, please print child’s name: ____________________________

Signature of Parent/Guardian ____________________________ Date________________

Client Signature:____________________________________________________________

As witnessed by: ____________________________ (Therapist)________________(Date)
West Texas Counseling & Guidance

Intake Form

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Referred by: ___________________________ Reason for referral: ___________________________

Reason for choosing West Texas Counseling & Guidance of San Angelo:

_____________________________________________________________________________________

_____________________________________________________________________________________

Client Information (See below for Adult/Minor Sections)

Last Name __________________________ First Name __________________________ Middle Initial ________

Birth Date: ___ / ___ / ___ Social Security Number ____________________ Gender: M F (circle)

Street Address ____________________________________________________________ Apt # ________

City __________________________ State __________________________ Zip ___________

Home telephone: _______________________________ Cell phone: _______________________________

May we call you? Y N May we leave a message? Y N

Religion/Denominational preference: __________________________ Congregation (if any): ___________

Military: Active_____ Inactive_____ Veteran_____ Dependent_____ Disabled_____

Racial/Ethnic identity: ___ African American ___ Native American ___ Asian American

___ White/Caucasian ___ Hispanic/Latino ___ Pacific Islander ___ Other: ________________

Emergency Contact: ____________________________ (name) Contact number: ________________

Relationship to the client: ___________________________

ADULT Client Information

Employment (circle) Full-Time Part-Time Homemaker Self-Employed Unemployed

Employer: _______________________________________________________________________

What type of work do you do? ____________________________________________________________________________________________
**Education** - Highest Level of Education Completed (circle)

GED   High School   Associate’s Degree   Bachelor’s Degree   Graduate Degree

Professional Certification   Other

Current Student  Y    N        School: _______________________ Studying: _______________________

**Family Information** (circle)

Single   Engaged   Married   Separated   Divorced   Widowed   Cohabitating

If married, how long? _____________   If divorced/widowed, when? _____________________________

Parents (circle):  Mother    Father    Living (age) _____    Deceased (date) ________

Mother    Father    Living (age) _____    Deceased (date) ________

Siblings  How many? ________   I am the (circle): Oldest    In the Middle    Youngest    Only Child

Names and ages of your children: _________________________________________________________

Names and ages of your step-children? ____________________________________________________

Who lives at home with you? _____________________________________________

Have any of your children died?  Y    N   (if Y, please provide details) __________________________

_____________________________________________________________________________________

What do you consider the most significant events in your life? ________________________________

_____________________________________________________________________________________

**MINOR Client Information**

Current grade: _______________________  School: _____________________________

Problems at school?  Y    N   If yes, please explain: ________________________________

_____________________________________________________________________________________

**Family Information**

Parents:  Married    Separated    Divorced    Cohabitating    Never Married
Mother: ____________________________  Full Custody  Joint Custody  No Rights  Other (circle)
Father: ____________________________  Full Custody  Joint Custody  No Rights  Other (circle)

If other, please explain: _________________________________________________________________

Is there a legal document outlining custody?  Y  N  (copy required)

Is the minor in the care of a guardian or conservator?  Y  N  If yes, who? ____________________

What is this person’s relationship to the child? _____________________________________________

Is there a legal document showing this agreement?  Y  N  (copy required)

Siblings: How many? _________  Ages: ____________________________________________

Client is the (circle):  Oldest  In the Middle  Youngest  Only Child

List everyone living in the home with the client (name & relationship): __________________________

_____________________________________________________________________________________

Significant events in the client’s life: ______________________________________________________

_____________________________________________________________________________________

**General Client Information (All Ages)**

Have the client or anyone in the client’s family experienced domestic violence or abuse?  Y  N

Is the client currently experiencing domestic violence or abuse?  Y  N

Has the client experienced mental health problems before?  Y  N

Does the client have a family history of mental health problems?  Y  N

Do you drink alcohol?  Y  N  On average, how many drinks do you have? _________ per _________

Do you use drugs?  Y  N  If yes, which ones? _____________________________________________

How often? ______________________ per ____________

What would you like to see happen as a result of counseling? ________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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What is your reason for seeking help now? _________________________________________________

Are any of the following conditions a problem to the client at this time? (Check the ones that apply)

- [ ] Thoughts of suicide
- [ ] Plans to harm self
- [ ] Thoughts of harming someone else
- [ ] Plans to harm someone else
- [ ] Self-injury
- [ ] Depression
- [ ] Grief
- [ ] Stress
- [ ] Loneliness
- [ ] Guilt feelings
- [ ] Loss of hope
- [ ] Loss of meaning in life
- [ ] Problems with sleep
- [ ] Anxiety
- [ ] Panic Attacks
- [ ] Chronic fear
- [ ] Irrational fears
- [ ] Problems due to abuse or trauma
- [ ] Obsessions/compulsions
- [ ] Behavioral problems
- [ ] ADHD
- [ ] Anger
- [ ] Rage
- [ ] Problems with relationship partner
- [ ] Sexual problems
- [ ] Sexual orientation
- [ ] Gender identity issues
- [ ] Relationship to parents
- [ ] Relationship to children
- [ ] Conflicts at work
- [ ] Problems in school
- [ ] Loss of faith in God
- [ ] Religious doubts
- [ ] Substance abuse
- [ ] Other? Explain: ____________________________

Medical History of Client

Primary Physician: __________________________ Date of last medical examination? ______________

List any physical illness or symptoms the client is having at this time: ____________________________
____________________________________________________________________________________
____________________________________________________________________________________

List major surgeries or illnesses in the last five years: ____________________________
____________________________________________________________________________________
____________________________________________________________________________________

List current medications: ____________________________
____________________________________________________________________________________

Physician prescribing medications for mental health issues: ____________________________
Has the client ever received help for drug or alcohol abuse?  Y  N  If yes, when and where?  
___________________________________________________________________________

Has the client ever been hospitalized for drug or alcohol abuse?  Y  N  If yes, when and where?  
___________________________________________________________________________

Has the client ever received help for mental health issues?  Y  N  If yes, when and where?  
_____________________________________________________________________________________

Has the client ever been hospitalized for mental health issues?  Y  N  If yes, when and where?  
_____________________________________________________________________________________

Acknowledgement

Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

________________________________________  ______________________________
Signature                        Date

Client / Parent / Guardian
West Texas Counseling & Guidance

Appointment Reminder Preference

Name: _______________________________

West Texas Counseling & Guidance may notify you of your next appointment 24 – 48 hours in advance as a courtesy reminder. Please choose ONE reminder option.

☐ Yes, I would appreciate a phone reminder. Please call me prior to my appointment at_______________________. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ Yes, I would appreciate a text reminder. Please text me prior to my appointment at_______________________. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ No, I would prefer not to be reminded of appointments and will keep up with them myself.

__________________________  ______________  
Client  Date

__________________________  ______________  
WTCG Staff  Date
When you schedule an appointment with our staff, West Texas Counseling & Guidance reserves that time just for you. That is why we require 24-hour advance notification of cancellation. Leaving a message on our voicemail is fine, even on weekends. The time you called will be posted with the message. Should you fail to show for your scheduled appointment or cancel less than the required 24 hours in advance, you will be charged the fee of $25 for missed sessions. If you are being seen for reduced fee and pay less than $25 per session, the fee will be your usual session charge. We appreciate the courtesy you extend to us by honoring this agreement. Please note that we cannot bill your insurance company for missed sessions or for late cancellations. You will not be seen again by your therapist until the fee is paid.

If we are billing Medicaid, an Employee Assistance Program, or certain third parties, the $25 fee may not be applicable. In this case, after two no shows or cancellations within 24 hours of your appointment time, you will not be allowed to reschedule an appointment. You may be placed on a call-back list to be seen the same day.

If you have three no shows or late cancellations within a calendar year, you may be discharged from services.

By signing this agreement I acknowledge my understanding of all the policies listed above.

I, the undersigned, accept and agree to all of the above terms during the course of my treatment at West Texas Counseling & Guidance.

___________________________________
Name of Client

___________________________________
Signature of Client Date

___________________________________
Signature of WTC&G Staff Date