southwest psychotherapy
ASSOCIATES

Ty David Lerman, LPC-S | Micki Grimland, LCSW
Andrea Washington, LCSW-S | Sue Steinbruecker, LCSW | Dianne Pulsipher, LPC
Angela Moore, JD, LCSW | Brian Kunde, LCSW | Brandy Lerman, LPC
Dr. Jeanette Christensen, DO | Tania Andrews, LMFT-A

INFORMED CONSENT FOR SERVICES

Contract for Services and Treatment

This contract is a reciprocal agreement with corresponding rights and responsibilities for all parties.

Statement of Understanding

I have chosen to receive services by a contracted therapist with Southwest Psychotherapy Associates, PLLC (SWPA). My choice is voluntary and I understand that I may terminate therapy at any time. Terminating services is an important part of the therapeutic process and it is always preferred that I speak with my therapist about termination in session, rather than over the phone or via electronic communication.

I understand that there is no guarantee that I will feel better because psychotherapy is a cooperative effort between my therapist and myself. I will work with my therapist in reaching my desired goals.

I understand that during the course of treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems. For example, a history of trauma or abuse may be discussed. With therapy there are possible side effects and some risks are involved. Therapy is often emotional and draining for the individual and things may appear to get worse before they get better. Anxiety and fear may result from dealing with and facing emotional issues. Relationships may change as I make changes in my personal life and gain increased self-awareness and understanding. As a result of my therapy sessions, my therapist may recommend me to a psychiatrist to evaluate the need for medication. Therapists at SWPA do not prescribe medications.

The Counseling Relationship

All providers are required to adhere to the Code of Ethics and Standards of Practice as put forth by the Texas State Board of Examiners of Professional Counselors and Social Workers, and Medical Board. These codes precludes dual relationships in order to protect the rights of clients and maintain objectivity and professional judgment of the provider. In the event that a relationship outside the therapeutic relationship is

unavoidable, the provider will discuss the situation with the client and resolve the issue with the client professionally and in a manner most suitable to the client's needs and best interests.

Legal Duties

State and federal laws require that your medical records are kept private. Such laws require that you are provided with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents disclosed in an evaluation, intake, or therapy session(s) are covered by law as private information. We respect the privacy of said information and abide by ethical and legal requirements, confidentiality, and privacy of records as mandated by HIPPA regulations. As contract therapists with SWPA, each therapist is solely responsible for the adherence of HIPPA regulations of creation, maintenance, and retention of client records, and SWPA, PLLC is not co-responsible for compliance of keeping proper client records.

Electronic communication (text/email) is not HIPPA compliant and confidentiality cannot be guaranteed. As such, electronic communication will be limited to logistical and administrative issues only and no clinical information will be discussed via this mode of communication. Instead, clients are encouraged to simply call their provider to speak with them.

Limits of Confidentiality

While HIPPA and the Right to Privacy Act bind providers of Mental Health Services, there are limitations set forth by state law and confidentiality may be breached for specific reasons detailed as follows:

- Client provides written consent to a specific person for a specific reason,
- Disclosure is required to prevent clear and imminent danger to the client or others,
- Client states or suggest report of confirmed or suspected abuse or neglect to a child, elderly, or disabled adult,
- When ordered by an official of the court, as required by law,
- Information required by insurance companies for payment (for which the client must provide written consent),
- Information provided to parents or legal guardian(s) if the client is a minor,

- Professional misconduct by a medical or mental health professional,
- Valid collection of a debt,
- Consultation with other professionals to aid in the treatment process (identifying information will be withheld unless client's written permission is given).

Financial Arrangements

The rate for an individual session is listed below by provider, unless otherwise negotiated with a provider. Additional time will be charged at the same rate, in 15-minute increments as needed. All phone calls will be charged the same rate/interval. Payment in full for all professional services is due at the time of services. The fee for less than 24-hour notice cancellation and missed appointments is the total fee of the session missed. You may pay by cash, check, or credit card. Checks should be made payable to: "SWPA". It is helpful to have checks made out prior to session. NSF returned checks are subject to a $30 service fee which must be paid at the next appointment, and future payments will be required to be made with cash, card, or money order. Because payment is due when services are rendered, bills are not sent out. If, however, a situation necessitates that you be billed, please remit payment within 15 business days of the date of invoice. If any account goes unpaid 15 business days after the date of service, the card on file will be run. If no card on file, or the card does not go through, a service charge of 1.5% will be added to the bill. 18% APR will be added to all overdue accounts after 30 days. The client will also be liable for all legal and collection fees incurred by SWPA. We understand that financial hardships arise, so please speak with your therapist about hardship pricing if needed. Current therapist fees are as follows:

Ty David Lerman, LPC-S	$250	Micki Grimland, LCSW	$210
Andrea Washington, LCSW	$190	Sue Steinbruecker, LCSW	$175
Dianne Pulsipher, LPC	$195	Brian Kunde, LCSW	$155
Brandy Lerman, LPC	$175	Angela Moore, JD, LCSW	$175
Tania Andrews, LMFT-A	$150 individual hour, $225 couples/family 1.5 hours		
Dr. Jeanette Christensen, DO	Intake (60 min) $450, Follow Up Sessions (30 min) $225		

Insurance

Your health insurance policy is a contract between you and your insurance company.

Should you choose to use your insurance, you may be eligible for "out of network" benefits. Usually a simple phone call to your insurance customer service will help determine this. By request, a client will be provided a "superbill" from SWPA for services rendered, which the client would then file with their insurance company for reimbursement. Where the provider can help guide this process, the client is solely responsible for researching and filing the necessary paperwork for insurance reimbursement. The client is also responsible for keeping track of their benefit requirements/limitations such as the number of sessions allowed per calendar year, authorized time periods, and so on. Should you choose insurance as an option, SWPA may be required to provide the company with personal health information for a client to be reimbursed, and a written release of information will need to be obtained. Be advised that once information is released, SWPA is not liable for information disclosed by an insurance company, and holds no responsibility for confidentiality procedures employed by any insurance company.

SWPA is also not a provider of Medicare or Medicaid services.

Court Appearance and Other Legal Matters

Clients are discouraged from having their therapist subpoenaed or providing records for the purpose of court proceedings. Providers of SWPA are NOT expert witnesses and can only testify as factual witness as documented in clinical progress notes, which are maintained for clinical purposes, and may hinder rather than help any legal proceedings.

If a provider of SWPA is to receive a subpoena of appearance, then the attorney or office staff is to call to set up a time for the subpoena to be served during the therapist's office hours. The hourly fee for all legal issues is the therapist's hourly rate, and time is charged in hourly increments. The client is charged for time including but not limited to: scheduled time to be served subpoenas or notarize documents, preparation time (including preparation of records), depositions, time spent on court premises (with or without testifying), travel time, consultation with lawyers, and all attorney fees and costs that are incurred by the therapist as a result of legal proceedings. Clients may pay by cash, check, or credit card. The client (or parent/guardian) is responsible for payment of all fees.

In the case of a court appearance, a full day of work must be rescheduled by the provider. As such, a day retainer based on your therapist's hourly rate (8 hours x hourly rate) is due at least 72 hours before the scheduled court appearance. Any additional costs will be billed to the client after the court appearance and will be due upon receipt.

If an account goes unpaid over 15 business days, the card on file will be charged. In the absence of a card on file, or if card is unable to be charged, a service charge of 1.5% will be applied. 18% APR will be added to all overdue accounts in monthly installments after court date. The client will also be liable for all collection fees. Any refund from the retainer owed to the client will be remitted by mail to the client's address of record no less than 30 days after completion of the court appearance.

Appointments and Course of Treatment

Appointment duration, times, and frequency will be determined based on the individual needs of the client. Generally, appointments last 45-50 minutes for individuals, couples, and families, and group times vary. Being late for an appointment by 20 minutes or more may require that you reschedule the session and the no show fee will apply. The session will end at the scheduled time, unless the late start is at the fault of the therapist and will be handled as the situation arises. The duration of therapy will be determined by the client's progress, the desired goals of the intervention, treatment type, and mutual agreement between the provider and the client. Upon termination of therapy, the provider will assist the client in finding other services or another therapist, when necessary.

Closure is an important part of the therapeutic relationship for both the provider and the client. For this reason, we encourage a final appointment for all clients that are ending therapy. Please do not end your therapeutic relationship via text/email.

Social Media Policy

Due to the importance of your confidentiality and in minimizing dual relationships, your therapist cannot accept friend or contact requests from current or former clients on social networking sites (Facebook, Linkedin, etc.). Adding clients as friends or contacts on these sites can compromise your confidentiality and your respective privacy. It would also blur the boundaries of the therapeutic relationship by creating a dual relationship.

Clients may follow SWPA, or your provider's professional social media accounts should they wish, however, there will be no direct communication with your provider through social media. Further, should you engage in any discourse on SWPA or provider accounts, you accept the possibility of jeopardizing your confidentiality. If you have questions about our social media policy, please bring them up with your provider in session.

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Client Rights

You have the right to request or receive your medical records. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parent(s) or legal guardian(s). You have the right to cancel a release of information by providing written notice. If you desire to have your information sent to a location different than your address on file, you must provide this information in writing with a signature. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing with a signature. You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the night to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. This request must be made to us in writing with a signature. If you desire a written copy of this notice, you may obtain it by requesting it in writing.

The terms and conditions of this contract can be renegotiated upon the request of the client and/or provider (with client approval) at any time.

If at any time the client has a problem or complaint against the provider, the client may grieve directly to the Department of State Health Services at customer.service@dshs.texas.gov, 512-776-2150 or 1-888-963-7111, ext. 2150; TDD 1-800-735-2989, or via mail at Department of State Health Services, attn: Customer Service Coordinator, PO Box 149347 MC-1913, Austin, Texas 78714-9347

Consent for Medical Treatment

The undersigned patient or responsible party (parent, legal guardian, or conservator) voluntarily consents to, and authorizes service as considered necessary by Dr. Jeanette Christensen, DO. These services may include telemedicine, psychotherapy, medication therapy, laboratory tests, diagnostic procedures, and other appropriate therapies.

The undersigned understands that he or she has the right to: (1) Be informed and participate in the selection of treatments; (2) Receive a copy of this consent; and (3) Withdraw this consent at any time.

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Informed Consent for Coaching

If you are out of Texas, you are entering a coaching relationship:

Coaching will not focus explicitly on suicidality or severe mental illness involving risk of your safety or the safety of others. For issues such as these, you must see a Physician or Licensed Mental Health Professional in your current state.

By signing this agreement, you are agreeing that you understand the difference between coaching and therapy and you will get appropriate professional help for mental health issues if necessary. Please feel free to ask questions at any time about your coach's background, experience, and professional orientation.

All information obtained in the course of the professional service is confidential unless there is a compelling professional reason for its disclosure. Your coach will disclose confidential information without a specific release if it is necessary to prevent foreseeable imminent harm to the client or another. In all circumstances, coaches will be judicious in the amount of information that is disclosed. Coaches may disclose confidential information without the consent of the client only as mandated or permitted by law. When possible, coaches inform clients about the disclosure of confidential information and possible ramifications before the disclosure is made. Coaches will only disclose confidential information to third parties with the appropriate written consent. Coaches must disclose certain confidential information as required by law or if the confidential information may put the client or others at risk of harm or compromise their well-being.

Everything possible is done to assure email and webcam confidentiality, but it cannot be guaranteed. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 or the appropriate emergency service to request assistance. It is outside the limits of the coaching relationship for a coach to be your emergency contact. In the case of a non-medical emergency, please contact your mental health or medical provider.

Coaches and clients are partners in the coaching process. You have the right to agree or disagree with your coach's recommendations. Your signature indicates that you have read this agreement for services carefully and understand its contents.

**Please print and keep the above for your records.

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Acknowledgement of Informed Consent

I, _____, have read and understand the above guidelines of the informed consent. I have been given the opportunity to ask questions and have been informed of the rights of confidentiality and my rights as a client. I understand that the contract for services portion of this contract can be renegotiated at any time by my request or consent. I agree with the treatment, procedures, and goals of therapy as discussed with the provider. Further, in the event of court proceedings, signed consent below allows the provider to testify verbally and/or in writing to counseling services received in specific conjunction with court orders. I am aware I can receive a copy of the informed consent and contract for services at any time by request.

_____ _____

Client Name (please print) Date

_____ _____

Client Signature & Parent/Legal Guardian Signature (if client is a minor) Date

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CLIENT INTAKE

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Cell Phone: _____ May we leave a message? □ Yes □ No
May we text for appointment confirmations? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
**Please note: Electronic correspondence is not HIPPA compliant, and is only used for administrative/scheduling purposes.*

DOB: _____ Gender: _____ Sexual Orientation: _____

Racial Identity: _____

Relationship structure (monogamous, open, polyam, etc): _____

Marital Status:
□ Single □ Domestic Partnership □ Married □ Separated □ Divorced □ Widow/er

Please list any children and ages:
_____

Whom may we thank for referring you?
_____

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History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

If yes, please list previous therapist/practitioner:

May we contact them to better coordinate your care? ☐ Yes ☐ No ☐ N/A

If yes, please provide phone number and/or email address:

Are you currently taking any prescription medication? ☐ Yes ☐ No

If yes, please list:

Have you ever been prescribed psychiatric medication in the past (other than listed above)? ☐ Yes ☐ No

If yes, please list and provide dates:

General and Mental Health Information

1. How would you rate your current physical health?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits?

□Poor □Unsatisfactory □Satisfactory □Good □Very good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

What types of exercise do you participate in?

4. Please list any difficulties you experience with your appetite or eating problems:

5. Are you currently experiencing significant sadness, grief, or depression? □ Yes □ No
If yes, for approximately how long?

6. Are you currently experiencing anxiety, panic attacks, or significant fear? □ Yes □ No
If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain? □ Yes □ No
If yes, please describe:

8. Do you drink alcohol more than once a week? □ Yes □ No
If yes, how many drinks do you have, on average, when you do drink?

9. Do you engage in recreational drug use? □ Yes □ No
If yes, what is/are your drug/s of choice?
If yes, how often do you use? □ Rarely □ Daily □ Weekly □ Monthly

10. Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, for how long? _____ Live together? ☐ Yes ☐ No
On a scale of 1-10 (with 1 being poor, and 10 being exceptional), how would you rate your satisfaction with your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Alcohol/Substance Abuse ☐ Yes ☐ No _____
Anxiety ☐ Yes ☐ No _____
Depression ☐ Yes ☐ No _____
Domestic Violence ☐ Yes ☐ No _____
Eating Disorders ☐ Yes ☐ No _____
Obesity ☐ Yes ☐ No _____
Obsessive Compulsive Behavior ☐ Yes ☐ No _____
Schizophrenia ☐ Yes ☐ No _____
Suicide Attempts ☐ Yes ☐ No _____

Additional Information

1. Are you currently employed? ☐ Yes ☐ No
If yes, what is your employment situation (part-time, full-time, temp, permanent)?

Do you enjoy your work? Is there anything stressful about your current work?

2. How has your racial identity played a factor in your life?

3. Have you served in the military? ☐ Yes ☐ No
If yes, which branch? _____ How long did you serve? _____
How has your service time impacted your life?

4. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No
If yes, describe your faith or belief:

5. What do you consider to be some of your strengths?

6. What do you consider to be some of your weaknesses?

7. What would you like to accomplish from your time in therapy?

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Card Information

I give SWPA, PLLC permission to charge my card for services rendered, in the event of a cancellation fee, or if a balance is left unpaid after 15 days from any date of service. I understand that my card information will be stored in the Square App, which is HIPPA compliant and my information will be secure. (Please print and physically sign before submitting to your therapist.)

X:_____

Client Signature, or Parent/Legal Guardian Signature (if client is a minor)

Date: ____/____/_____

Name on Card: _____

Card Type: _____

Card Number: _____

Expiration Date: ____/_____

Security Code (back of card): _____

Billing Zip Code: _____

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SWPA Emergency Contact Sheet

In case of emergency, SWPA's providers have permission to contact the following individual(s):

1) Name _____ Relationship to Client _____

Address _____ Telephone _____

2) Name _____ Relationship to Client _____

Address _____ Telephone _____

Client Name (print) _____ Date _____

Client Signature & Parent/Legal Guardian Signature (if client is a minor) _____ Date _____