

CLIENT INFORMATION AND CONSENT

Therapist:

The undersigned therapist is a Licensed Professional Counselor- Intern, engaged in private practice providing mental health care and chemical dependency counseling services to clients directly. The undersigned therapist provides mental health and chemical dependency counseling services through Lois Thomson-Bowersock and educational services d/b/a The Parents' Coach.

Mental Health/Chemical Dependency Counseling Services:

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings, thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by your therapist.

Appointments:

Appointments are made by calling (281) 419-5255 Monday through Thursday between the hours of 9:00 AM and 6:00 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.

Office Location:

All services, unless otherwise agreed upon in advance, will be conducted at the therapist's office, located at:
1733 Woodstead Court, Ste #101
The Woodlands, Texas 77380

Number of Visits:

The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits:

Therapy sessions are 60-75 minutes in length. Group therapy sessions are 75-90 minutes in length.

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 have a social or personal relationship with you.

Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

Cancellations:

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged the customary fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment.

Payments for Services:

During regular business hours the charge for individual sessions is \$100.00, and the fee for couples sessions is \$120.00. The charge for after-hour sessions (evening appointments after 6:00 PM or weekend appointments held on Friday, Saturday or Sunday) is \$ 120.00, for individual sessions and \$140.00 for couples sessions. The charge for group therapy sessions is \$35.00. Services rendered at locations other than the therapist's office address indicated above, will be charged at a rate of \$ 140.00 per hour.

The undersigned therapist does not accept assignment of insurance benefits. The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges.

You are responsible for and shall pay your portion of all the undersigned therapist's charges for services at the time the services are provided. Cash, check, and all major credit cards are accepted for payment of your account. You are advised that payment of your account with check or credit card could provide sufficient information to financial institutions and their employees to identify you as a client of the therapist. This identification by association can be minimized by using cash for the payment of the services provided by the therapist.

Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or testimony is 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 for the time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the therapist.

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 the issue; situations where the therapist has a duty to disclose, or where, in the therapists judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss the matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for these services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

The undersigned therapist is required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of your privacy rights and the therapist's legal duties and privacy practices with respect to your PHI. The undersigned therapist is required to abide by the terms of the Notice of Privacy Practices with respect to your PHI but reserve the right to change the terms of the notice and make the new notice provisions effective for all PHI that she maintains. The therapist will provide you with a copy of the revised notice sent by regular mail to the last address you have provided to the therapist for this communication purpose. The Notice of Privacy describes how mental health information about you may be used and disclosed and how you can get access to this information. You are advised to read it carefully.

Duty to Warn:

In the event that the undersigned therapist reasonably believes that I am in danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name of Emergency Contact Person

Telephone Number(s)

Name of Emergency Contact Person

Telephone Number(s)

Name of Emergency Contact Person

Telephone Number(s)

Mail, Telephone, Fax &/or E-mail Consent:

I consent for the undersigned therapist to communicate with me by mail and by telephone at the following addresses and telephone numbers, and I will IMMEDIATELY advise the therapist in the event of any change:

Mailing Address: _____

Telephone Numbers: _____
Home _____ Work _____
Cell _____ Fax _____

I consent for the undersigned therapist to communicate with me by e-mail and the following e-mail address and I will IMMEDIATELY advise the therapist in the event of any change:

E-Mail: _____

Risks of Therapy:

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel a wide range of feelings and emotions, including sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

After Hours Emergencies:

Emergencies are urgent issues requiring immediate action. You may contact Kimberlea Saltzman by cell-phone at 281-989-5106. In the event of an emergency requiring immediate psychiatric or medical attention please telephone 911 and/or obtain emergency services at your nearest hospital. In the event suspected overdoses of mood-altering substances such as alcohol, prescription medications and/or illicit drugs, you are advised to seek immediate emergency medical services.

Therapist's Incapacity or Death:

I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

Consent to Treatment:

I, voluntarily, agree to receive mental health &/or chemical dependency assessment, care, treatment or services, and authorize the undersigned therapist/counselor to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment or services that I receive through the undersigned therapist/counselor at any time.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client/Parent

Client/Parent

Social Security Number

Date of Birth

Social Security Number

Date of Birth

Address

Address

Date

As witnessed by:

Kimberlea A. Saltzman, BS, MA, LPC-Intern, NCC
Lois Thomson-Bowersock & Associates, LLC
1733 Woodstead Court, Suite 101
The Woodlands, TX 77380
Dr. Van Wiesner, LPC-Supervisor

Date