LOIS THOMSON BOWERSOCK & associates, llc
1733 Woodstead Ct. Suite 101, The Woodlands, TX 77380
Phone: (832) 326-9995 Fax: (281) 419-5251
E-Mail: vmb3phd@gmail.com Web: www.loisbowersock.com

New Client Information and Consent

Vaughn M. Bryant, III, PhD, LPC-S, LMFT-S, LCDC-CCS

Therapist:

The undersigned therapist has been a mental healthcare provider for over 30 years. His career has included work in college and universities, mental health clinics, hospitals, substance use disorder treatment centers, military hospital and pastoral care ministry. He is licensed by the Texas Department of State Health Services as a Marriage and Family Therapist (LMFT-S), Professional Counselor (LPC-S) and Chemical Dependency Counselor (LCDC-CCS). He also holds supervisor status on all three of those professional license boards. Vaughn has a Bachelors of Psychology, Masters of Marriage and Family Therapy and a Doctor of Philosophy in Psychology and Christian Counseling.

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 you 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 (832) 326-9995 Monday through Friday 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, Suite 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 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.

Social Media:

Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted.

Payments for Services:

- Individual Sessions - regular business hours - $150.00
- Individual Sessions - after hours (Saturdays, Sundays or holidays) - $175.00
- Joint or Family Sessions - regular business hours - $175.00
- Joint or Family Sessions - after hours (Saturdays, Sundays or holidays) - $195.00
- Telephone or email communications - regular business hours - $150.00. No fee will be charged for telephone calls or email communications that do not exceed 10 minutes.
- Telephone or email communications - after hours (Saturdays, Sundays or holidays) - $175.00
- Group Therapy Sessions - $75.00 per person per session (unless otherwise indicated)

The charge for a Substance Abuse Assessment conducted for the purpose of providing a corresponding written report to a third-party, is $500.00. Additional fees are not charged for Substance Abuse Assessments deemed necessary by the therapist to provide standard quality services to the client.

Services rendered at locations other than the therapist's office address indicated above, will be charged at a rate of $300.00 per hour, plus expenses. Automobile mileage will be charged at the current IRS rate.

The charge for additional services requested by the client (such as reviewing files, writing letters, writing reports or communicating with third parties etc.) is $175.00 per hour during regular hours and $195.00 per hour during after-hours (Saturdays, Sundays or holidays).

The undersigned therapist does not accept assignment of insurance benefits. You are responsible for payment in full of all charges and for filing a claim for any reimbursement from your insurance provider.

All charges for services shall be paid in full 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.

Confidentiality:

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.

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 therapist's 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 you are in danger, physically or emotionally, to yourself or another person, you specifically consent for the therapist to warn the person in danger and to contact the following person(s), in addition to medical and law enforcement personnel:

Name of Emergency Contact Person	Telephone Number(s)
Name of Emergency Contact Person	Telephone Number(s)

Marital or Joint Therapy:

By signing this intake and consent form below, you give your consent for Lois Thomson Bowersock & Associates, LLC, to maintain a single file for each joint therapy session in which you and _____ _____, (your spouse/family member) participates and for either you or your spouse/family member to have the right to access all the information recorded by the therapist in the joint file at any time.

Email and Text Messaging:

Lois Thomson Bowersock and Associates, LLC, uses and responds to email and text messages only to arrange or modify appointments. Please do not send emails related to your treatment or therapy sessions as such electronic communications are not completely secure and confidential. Therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during your next session. You should know that any emails or texts received from you and any responses sent will become part of your therapy record.

I consent for the undersigned therapist to communicate with me by mail, by telephone and by text messaging at the following address 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 email and the following email address and I will immediately advise the therapist in the event of any change:

Email: _____

Risks of Therapy:

Therapy is the Greek word for change. Often, growth cannot occur until you experience and confront issues that induce you to experience 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. 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. After first obtaining emergency care, then contact the undersigned therapist.

Therapist's Incapacity or Death:

You acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your file and records. By signing this Information and Consent Form, you give your consent to allow another licensed mental health professional selected by the undersigned therapist to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

Defamation:

By signing this Information and Consent Form below you agree you will not make or post defamatory commentary about Lois Thomson Bowersock & Associates, LLC, on any web site or social media site. In the event that defamatory remarks about Lois Thomson Bowersock & Associates, LLC, are made by you, or others acting in concert with you, you further consent by signing this Information and Consent Form to allow Lois Thomson Bowersock & Associates, LLC, to use confidential information necessary to rebut or defend against, or prosecute claims for the defamation.

Distance or Virtual Counseling:

All electronic communications between you and the undersigned therapist will be transmitted using the encryption software referenced in the Consent to Treatment section below. You will be responsible to secure and protect the functionality, integrity, and privacy of your hardware, files, and communication. Password protection for accessing your hardware and files is recommended. If others will be accessing the same computer or electronic device, be aware that programs exist that copy every keystroke you make. It is recommended that you schedule your sessions with the undersigned therapist when and where you can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session.

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Consent to Treatment:

I voluntarily agree to receive mental health and/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.

I agree to conduct any virtual online counseling sessions with Lois Thomson Bowersock & Associates, LLC, through Secure Video, www.securevideo.com in order to comply with HIPAA standards for protected health information (PHI).

By signing this Client Information and Consent form, I, the undersigned client/parent, 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.

Name of Client:_____

Address: _____

_____

Date of Birth: _____

Date: _____

_____ _____

Signature of Client or Parent/Guardian Printed Name of Parent/Guardian (if applicable)

Signature of Witness Printed Name of Witness

_____ _____

Witness Witness (printed)

Lois Thomson Bowersock & Associates, LLC

_____ _____

Vaughn M. Bryant, III, PhD, LPC-S, LMFT-S, LCDC-CCS Date

1733 Woodstead Court, Suite 101

The Woodlands, Texas 77380

Notice of Privacy Practices of Lois Thomson Bowersock & Associates, LLC

Revised January 1, 2018

Lois Thomson Bowersock & Associates, LLC/ Vaughn M. Bryant, III, 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 our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this notice with respect to your PHI but reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that we maintain. We will provide you with a copy of the revised notice sent by regular mail to the last address you have provided to us for this communication purpose.

HIPAA Privacy Notice Acknowledgement

I have been provided and have received Lois Thomson-Bowersock & Associates, LLC's Notice of Privacy Practices revised January 1, 2018.

_____ _____

Signature of Client or Legal Representative | Printed Name of Client

_____

Date

_____ _____

Signature of Client or Legal Representative | Printed Name of Client

_____

Date

I request that changes to the Notice of Privacy Practices be sent to me at this address:

_____

Witnessed:

_____

Signature of Witness

_____

Date