

HOOD COUNTY COUNSELING CENTER
Belinda Tuck Counseling Consent Form

Welcome. This patient information form will answer most of your questions about therapy services at my office. Please feel free to ask for clarification or additional information at your initial visit. The nature of therapy will be explained to you in simple, non-technical terms and, the period of treatment is dependent upon your current issues and willingness to participate in the therapy process.

Confidentiality: By law and professional ethics, your sessions are strictly confidential. No information will be shared with any entity or person without your written permission. If you are seeing another therapist or health professional it may be necessary for our office to contact this individual, so that we can coordinate our treatment efforts. If this is necessary I will ask for your permission. In addition, some insurance companies require periodic updates. I will only provide this information with your permission. Typically, insurance companies only require the following information: length of illness, psychiatric diagnosis, dates of service, and the names of persons being treated. There are however, a number of exceptions to this confidentiality policy.

- If I am ordered by the court to testify or release records.
- If you are a victim or perpetrator of child abuse, I am required by law to report this to the authorities responsible for investigating child abuse.
- If you are a victim or perpetrator of elder or dependent adult abuse, I am required by law to report this to Adult Protective Services or other appropriate authorities.
- If you threaten harm to yourself, someone else or the property of others, I may be required to call the police and warn the potential victim, or take other reasonable steps to prevent the threatened harm.
- Shared information between office staff for billing or treatment modalities (includes supervision of intern staffing)

Treatment of a minor without parental consent is allowed by law (Civil Code 25.9) if:

- The minor is 12 years of age or older, and the minor is mature enough to participate intelligently in outpatient mental health treatment or counseling, and the minor has been the alleged victim of incest or child abuse, or without such mental health treatment or counseling the minor would present a danger of serious physical or mental harm to himself/herself or others.

Fees:

Individual/Family -	\$125.00 per session
Marriage Counseling -	\$125.00 per session
Telephone consultation -	\$35.00 (per 15 minute increment)
Hypnosis -	\$100.00 per session
Court Appearances -	\$1,500.00 per day
Court Paperwork -	\$250.00 per hour

My fees are based on a 45 to 50 min. hour. You are expected to pay for the counseling at the beginning of each session or the co-payment required by your insurance company. Our facility accepts **"E-Z Pay"** (see attached form) for your convenience.

Staff: Our staff consist of a licensed professional counselor Belinda Tuck and periodically student interns, and licensed professional counseling interns under the direct supervision of Belinda Tuck, L.P.C.S (licensed professional counselor supervisor by the Texas State Examiners of Professional Counseling.)

Cancellations: You will be charged a fee of **\$60.00 for all missed appointments that have not been cancelled 24 hours in advance of the appointment, this fee cannot be charged to your insurance company and you will be fully responsible for the payment.** Frequent cancellations may result in your losing your regular appointment time and having to schedule our meetings based on my availability each week. Periodically, I will have to cancel sessions due to mandatory court appearances. If this occurs I will notify you promptly so that we can reschedule our session.

Treatment: Therapy is the process of solving emotional problems by talking with a person professionally trained to help people achieve a more fulfilling individual life, marital relationship, or family relationships. The therapist may choose to utilize a variety of techniques derived from theories of psychotherapy and may include the use of hypnosis, EMDR and Alpha-Stim therapy. Use of hypnosis or Alpha-Stim will require an assimilation of information to the client of potential risk and benefits and require a signed informed consent form from the client per procedure elected. I understand that I am free to discontinue treatment at any time, but it is asked that the client participate in a termination session.

In addition, I fully acknowledge, understand and agree that any insurance benefits quoted to Belinda Tuck Counseling or myself are subject to change and/or modification once claims are submitted. Further, I understand that I will be responsible for any and all other charges that my insurance denies. _____ (Initialed by client)

By my signature, I am indicating I have read and understood this consent form and voluntarily consent to treatment at Belinda Tuck Counseling.

Signature of Client: _____ Date: _____

Signature of LPC/LPC Intern: _____ Date: _____

iE-Z Pay Option

Due to the emotionally volatile nature of counseling sessions, this payment option allows you the convenience to have your session billed directly to your credit card.

MasterCard /Visa # _____ Exp. _____

DiscoverCard# _____ Exp. _____

American Express# _____ Exp. _____

Name as it appears on card _____

I understand that I am authorizing Belinda Tuck Counseling to charge my credit card for each session that I do not provide another form of payment before the session ends.

Signature of Client: _____ Date: _____

(IF APPLICABLE):

I understand that I will be seen by a licensed professional counselor intern for professional services under the supervision/direction of Belinda Tuck. I understand my case will be discussed and monitored closely by Belinda Tuck, LPC, and I may contact her in regards to my counseling experience.

Signature of Client: _____ Date: _____

Signature of LPC Intern: _____ Date: _____