Client Rights & Informed Consent

Overview of Therapy
As a professional, I do not prescribe medications, but I am trained in a broad range of techniques. The goal of therapy is to help you identify goals and potential solutions to problems which cause emotional turmoil. I cannot guarantee any specific results regarding your counseling goals, however, I aspire to work with you as meticulous and diligently as I can to achieve the best possible results. For further questions and concerns regarding my services please feel free to contact me. If necessary, I will provide other treatment options and/or referrals as needed.

While our sessions might be psychologically intimate, it is important for you to realize that our relationship is professional rather than social. Other than the scheduled meetings, our contact will be limited to the appointments you arrange with me. As a client, you will be best served if our relationship remains strictly professional. Our relationship will concentrate exclusively upon your goals and concerns.

Confidentiality
As required by **HIPAA** (health insurance portability act) regulations, the information that you provide in session is confidential and will not be shared with anyone without your written consent as prescribed by law. However, there are a few circumstances in which confidentiality, by law, will **NOT** be maintained, including the following:
- Concern of imminent harm to yourself (suicide) or others (homicide);
- Crucial information regarding your physical or emotional well-being;
- Suspicion or knowledge of abuse, neglect, or exploitation towards a minor or vulnerable adult;
- Litigation brought against me or the organization by the client;
- Order for release of records or attendance to court by any order of the Court
- Requirement for mental health services
- Any other situation required by law.

*Your right to confidentiality is important. Knowing this, your session will not be recorded (video or audio) and photos of you will not be taken without your written consent. It is important that you also do not record or take photos while in session.

Coverage/Emergencies

If you are experiencing danger or a life-threatening situation or emergency, call 911 or go to your nearest emergency room immediately. Contact in between sessions will be serviced via email crystalperryman2@gmail.com. Your call, message, and/or email will be responded to as soon as possible.

Sessions/Fees
Therapy sessions are typically 30 to 60 minutes in length. The remainder of the hour is used to chart notes, file. An additional fee applies when sessions exceed 60 minutes. Any fees incurred are due at the time services are rendered. Acceptable forms of payment include **cash**, **money order**, **HSA's, debit card**, or **credit card**. We accept payment via CashApp, PayPal, Zelle. If you are receiving services paid for by another party, the fees remain your responsibility until paid. If you need records summaries or letters written on your behalf, there is a $50 fee for each request.

Appointments and Cancellations
It is your responsibility to be present at your scheduled session time; being on time will ensure that you receive the full scheduled time. In the event you are unable to keep your scheduled appointment commitment, please be sure to cancel within 24 hours of your scheduled session. A **$50 fee** will be assessed to missed appointments or cancellations made after 24 hour grace period; this excludes emergencies. (Fee must be paid at or prior to next session)

Client Rights and Agreement
- I understand that I have chosen to undergo counseling, that this choice is voluntary, and that I may terminate services at any time. I understand that there is no assurance that I will feel better. I understand that counseling is cooperative and collaborative in nature and that I must actively engage in the process to effect change. I understand that during my session, subject matter may be discussed that is of a sensitive nature, and that this may be necessary for my healing, growth, and restoration process.
- I acknowledge that I am aware that this is **NOT** a medical relationship and that I will **NOT** be provided medical services such as diagnosis, and/or medication prescriptions.
- I understand I am responsible for **ALL** payments assessed via scheduled appointments. Sessions are 30-60 minutes in length and I am responsible for being on time in order to receive the full experience.
- I understand that if I am signing consent for a minor (17 years and under), I have authority to give consent. I will provide proof in the form of legal documentation if necessary.
- I acknowledge that I will be responsible for any late fee of **$50** for any missed or improperly canceled appointment.

I have read, understand, and agree to these policies, and certify that all the information on this form is true:
Client Printed Name(s): _____
Client Signature(s): _____ Date: _____
Parent/Guardian (if minor): _____ Date: _____
Therapist Printed Name/Credentials: _____
Therapist Signature: _____ Date: _____

Receipt of HIPAA Notice of Privacy Practices
I acknowledge notice of availability of Notice of Privacy Practices. I understand a copy of this document can be
provided at my request. I certify that I have read the Federal HIPAA Ruling provided by this practice.

_____ _____
ClientSignature(s) Date

_____ _____
Parent/Guardian Signature (if applicable) Date

• Texas Behavioral Health Executive Council
Complaints: Texas Behavioral Health Executive Council
Attn.: Enforcement Division
333 Guadalupe St., Ste., 3-900
Austin, TX 78701

• Texas State Board of Examiners of Licensed Clinical Dependency Counselors
Complaints Management and Investigative Section
P.O. Box 141369
Austin, TX 78714-1369

Billing Information/Rate Confirmation/Authorization of Assignment of Benefits:
Zoe` Therapy (Full Price Value of Sessions):
Individual 30 min Session: $50
Individual 60 min Session: $100
Family/Couples Counseling: $150:
Initial Below:
_____ I understand that the agreed upon contracted rate per session will be: _____.
My signature below signifies my acknowledgement and acceptance of the above, and if applicable, authorizes my Plan/Third Party to obtain information to carry out processing, and authorizes my Plan/ Third Party to make payments directly to **Zoe` Therapy**.

_____
Signature of Client

_____ _____ _____
Party Responsible for Payment Relationship to Client Phone

_____ _____
Address, City, State, Zip (if different from client's address) Additional Phone
Payments are due in full at the time services are rendered via Cash, ($30 returned check fee), or Credit Card on file; Payments also accepted via CashApp, PayPal, Zelle, ApplePay, Website