Terri Lively, LCSW

INFORMED CONSENT FOR INDIVIDUAL THERAPY, TREATMENT AGREEMENT FOR PSYCHOTHERAPY AND OFFICE POLICIES

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

PSYCHOTHERAPY SERVICES

I conceptualize psychotherapy from a systems perspective, in which the experiences of an individual is interrelated, both influencing and being influenced by the behaviors of the other member(s) of the individual's relationship or family. Within this general framework, I generally approach therapy from an integrative theoretical orientation, which means that I try to choose theoretical approaches suited to the particular presenting issues and concerns of the client. For example, I typically draw from cognitive-behavioral theory to address communication skill deficits, whereas insight-oriented approaches may be better suited to address emotional relationship trauma. I view psychotherapy as a collaborative task, in which you take an active role in working toward your goals, both within and between sessions.

A therapist helps clients with mental, emotional, cognitive, and behavioral difficulties. Psychotherapy is intended to help you reach a better understanding of specific problems or increased self-awareness. It is also intended to work toward improvement of the identified problems, offer support in problem solving, provide some symptom relief, and improvement in coping with daily life activities. Your progress in psychotherapy and its outcome depends upon many factors including but not limited to your level of motivation and desire to change, the effort that you put forth in following through with agreed upon therapeutic tasks outside of session, keeping your appointments, and your willingness to be open with me as we work together.

Therapy may have both risks and benefits. It often involves discussing difficult or unpleasant aspects of your life, and you may experience uncomfortable feelings about these discussions, such as sadness, guilt, anger, and frustration. Some of the changes you make as a result of psychotherapy may not be welcomed by other people in your life. This may result in some strain in your relationships with family and others. Therapy may disrupt a romantic relationship. Sometimes, too, it is possible for a client's problems to worsen immediately after beginning therapy. Most of these risks are to be expected when people are making important changes in their lives.

On the other hand, research has shown that therapy may also be beneficial, leading to improvements in individual psychological health, communication and problem-solving skills, and relationship satisfaction. It is important to understand that there are no guarantees about what you may experience during therapy or how therapy may affect you.

I have read, understood and agreed to the foregoing section: _____

INITIAL ASSESSMENT

Our first session, and possibly the first few sessions, will involve an assessment of your therapy needs and goals. There are several possible outcomes of this initial assessment, as it is an opportunity for us to decide if working together may beneficial for you.

If my therapeutic approach appears to fit with your individual goals, I will offer you some first impressions of what our work will include if you decide to continue with therapy. I encourage you to evaluate this information, along with your own opinions of whether you feel comfortable working with me, in deciding whether to continue with therapy. If you have any questions about my procedures during the initial assessment, or at any point in subsequent treatment, please bring them to my attention.

Therapy involves a commitment of time, money, and energy, so you should be careful about the therapist you select. If you decide to continue with treatment, then we will move toward scheduling therapy sessions. If, after our initial assessment, you believe that you would be more comfortable working with another mental health provider or I believe that another mental health provider may be better suited to assist you with your specific concerns, I will be happy to provide referrals.

I have read, understood and agreed to the foregoing section: _____

THERAPY SESSIONS AND ATTENDANCE

If psychotherapy is begun, we will schedule therapy sessions at a mutually agreeable interval. Sessions are 50 minutes long. When an appointment time is scheduled, you will be expected to pay a $75.00 missed session fee for the session unless you provide 24 hours advance notice of cancellation. If you determine more than 24 hours in advance that you may be unable to attend, please contact me so that you can schedule an alternative time. Insurance companies do not pay or reimburse for missed appointment fees.

Together we will typically agree on specific goals for therapy, such as symptom reduction, behavioral change, improved communication and/or interpersonal skills, the

ability to return to work or school, and I will prepare a treatment plan. Goals will in all likelihood change as the therapy progresses and should be renegotiated accordingly. The therapeutic approach used will vary and should be discussed with me whenever you have questions or when you believe therapy is not helpful.

How long you remain in therapy and the frequency of sessions is a matter best discussed while we work together to achieve your goals. While it is your right to end therapy at any time, when you decide to end treatment it is in your best interest to discuss this with me beforehand.

Parents. If you are a parent your participation in your child's counseling is important for long-term gains. You may need to learn a different way of dealing with your child to facilitate and maintain gains. I will ask for your feedback and views on your (your child's) therapy, progress and other aspects of the therapy and will expect you to respond openly and honestly.

Minors. When working with minor clients I will initially meet with all involved parents or caregivers before meeting with the client. From that point forward all discussions about clinical matters and concerns about the client will be done in the presence of the minor. Meetings without the client present tend to undermine the trust and therapeutic relationship. How frequently parents attend is something that can be negotiated at the outset of treatment and can be adjusted as needed.

Minor clients and all involved parents need to agree to rules for confidentiality. I will provide parents only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. However, if I believe your child is in physical danger, or someone else is in physical danger, I will alert the parents. If the situation calls for a report to local law enforcement or Child Protective Services, I will contact these entities as well.

Additionally, if you are a parent or guardian who is consenting to treatment for a minor, by signing this Agreement, you affirm that you are the parent or legal guardian of the child; that you have the legal right to consent to psychological treatment for the child; that there has not been a Divorce Decree or any other Court Order that limits your ability to consent to the child's treatment. If the child's parents are divorced or never married, it is my practice to require BOTH parents to consent to treatment, in compliance with any Divorce Decree or Court Order that may be in place. I will also require a copy of the Divorce Decree or Court Order prior to providing any services to the child, and by your signature below, you agree to provide it immediately upon request.

In my practice, if the parents of the child client have remarried or have significant others who may be involved in the child's therapy, I like to meet with all the adults before seeing the child to obtain signed Authorizations for the limited sharing of information regarding the child, and to establish the boundaries for my treatment of the child. I ask that none of the adults should ask to speak with me before the child's appointment in front of the child. If you have information to share, please do it privately. In order for step-parent(s) to make therapy appointments for child clients, the child's parents must sign an Authorization allowing the step-parent(s) to schedule the child's appointments.

I have read, understood and agreed to the foregoing section: _____

TERMINATION OF TREATMENT

It is my hope that when the time comes we will mutually agree about having met your treatment goals. At that at that time, we will schedule final sessions to review your progress and develop a plan to help protect you and your relationship(s) from future distress. However, there are a few instances in which I may terminate our work together before reaching that point. If I believe that my approach and training is no longer appropriate for your specific concerns, or that you are not benefitting from treatment, I will inform you that I can no longer provide services and give you referrals to other mental health professionals who may be better suited to meet your needs.

I understand that any termination may be difficult, but my decision on this matter will be final. If you make an authorized, written request, I will confer with your new therapist to help with the transition. Upon termination of therapy for any reason, the termination will be confirmed in writing.

In addition, if you schedule a session and do not attend the session or call me within 14 days of that appointment, I will understand that as a termination in our services. If you wish to resume services after this occurs, please contact me.

I have read, understood and agreed to the foregoing section: _____

PROFESSIONAL FEES

My hourly fee for a single therapy session is $150.00. In addition to therapy appointments, I may charge my standard $150.00 hourly fee for other professional services you may need, although I will prorate the hourly cost if I work for periods of less than one hour. Other services may include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

I have read, understood and agreed to the foregoing section: _____

LITIGATION POLICY AND FEES FOR COURT-RELATED SERVICES

If you become involved in any legal proceeding during your therapy with me, including but not limited to divorce and custody disputes or personal injury lawsuits, you agree that neither you, nor your attorneys, nor anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court, in a deposition, or in any legal proceeding. By your signature below, you acknowledge my position and agree to abide by my litigation policy.

If you involve me in your litigation, or if you or your attorneys subpoena me to provide my records, testify in court or give a deposition in violation of this agreement and against my stated wishes, I will comply as required by law with lawfully issued subpoenas. **My hourly charge for all time related to court cases or litigation is $375.00 per hour. You also agree by your signature below to execute and sign a Credit Card Authorization and provide a valid credit card to ensure payment for time spent preparing for and participating in your litigation.**

If I am subpoenaed to provide records or testimony in violation of this agreement and against my stated wishes, you also acknowledge and agree that you will pay for all of my professional time, including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, and time spent testifying in court or deposition **regardless of which party issues the subpoena or requires me to testify**.

If I am required to testify in court or give a deposition in Fort Bend County, I will charge a retainer fee of $1,500.00 (for a minimum of 4 hours at $375.00 per hour), which includes preparation time, travel time (door-to-door), and attendance at any legal proceeding. If I am required to testify in court or give a deposition outside of Fort Bend County, the retainer fee will be $2,250.00 (for a minimum of 6 hours at $375.00 per hour). If the testimony or deposition exceeds 4 hours (in Fort Bend County) or 6 hours (outside Fort Bend County), I will invoice you for all additional time spent in court, legal proceedings or deposition at the rate of $375.00 per hour. Payment will be due immediately upon receipt of that invoice.

When I am required to go to court or give a deposition, I must clear my schedule and not see other clients, so there is a 72-hour cancellation policy for court and depositions. For example, if the court appearance or deposition is scheduled for Monday, this office must be notified of any cancellation no later than Noon on the Thursday before. Any

cancellations that occur within the 48-hour time frame of the court appearance or deposition are **NON-REFUNDABLE**.

I will accept cash, money order, cashier's check, or credit cards for payment of time related to court appearances or deposition. All payments are due 48 hours prior to the scheduled court appearance or deposition, and no later than 12:00 Noon on Thursday if the court hearing/deposition is scheduled for a Monday. By your signature below, you expressly authorize me to run these charges to the credit card on file in our office unless you notify me in writing that you intend to make payment by cash, money order or cashier's check.

Finally, if I am subpoenaed by one party to provide records or testimony in violation of this agreement and against my stated wishes, I reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers.

I will not perform social studies or custody evaluations. I will not provide recommendations regarding possession, custody, access to or visitation with minor children. I will not conduct assessments for FMLA or short/long term disability applications. I will not provide medication or medical advice. I will not provide legal advice. These services are outside the scope of my practice.

I have read, understood and agreed to the foregoing section: _____

BILLING AND PAYMENTS

You will be expected to pay the fee or the copay for each session either before or at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. Payment may be made in the form of cash, personal checks, PayPal, or credit/debit card (Visa, MasterCard, or Discover). **If any amount remains unpaid, no additional sessions will be scheduled until the balance is paid in full**.

I am in the network with some insurance companies. As a courtesy to you, my office will check your insurance benefits as long as you provide the required information at least 2 business days before your scheduled session. If you don't provide the information in the requested time frame, you will be expected to pay $150.00 at the time of service. My office can provide you with a receipt that you may file with your insurance to seek some reimbursement.

Most insurance plans have an annual deductible, which must be met prior to reimbursement. If you have such a deductible, you are responsible for the payment of

all fees until that deductible is met. Some insurance plans require the insured to call prior to the first visit and obtain authorization for a specified number of visits, and your therapist is not allowed to call for you. If you fail to obtain this authorization before your first scheduled appointment with me, you are responsible for the full payment of my fee.

Regardless of the above, you (not your insurance company) are ultimately responsible for full payment of my fees, and for knowing what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administration directly.

I have read, understood and agreed to the foregoing section: _____

CONTACTING ME

Other than session attendance, I may be contacted by phone at (281) 494-9100. My office hours vary and I am often not immediately available by telephone. You may text the above phone number with scheduling questions. Please do not use text to communicate personal issues.

I routinely return calls within 12-24 hours during regular business hours, Monday through Friday, 10:00 a.m. to 7:00 p.m. If you are difficult to reach, please inform me of some times when you will be available when leaving a message. Please set your phone to accept private calls, otherwise I may be unable to reach you.

If you experience a life-threatening emergency and I am not available by telephone, you should go immediately to the nearest hospital emergency room and request to see a mental health professional. Another option is to call 911. If you are suicidal you can call the National Suicide Prevention Lifeline at 800/273-8255 24 hours a day**.** If you have insurance you can call the number listed on the back of your card and get a referral to an in-network psychiatric hospital for consultation with an intake specialist.

I have read, understood and agreed to the foregoing section: _____

USE OF ELECTRONIC COMMUNICATIONS

I prefer to use email for scheduling issues only. I can better protect your confidentiality if we keep more personal information in your sessions. Any e-mails you send to me will be printed and will become part of your clinical record.

I do not allow audiotaping of sessions unless we have agreed otherwise in advance.

I have read, understood and agreed to the foregoing section: _____

INTERACTIONS OUTSIDE THE OFFICE

If we happen to encounter each other outside of the professional setting I will not address you unless you address me first. This is also for the protection of your privacy from those either of us may be with. I'm happy to return a friendly greeting, but will allow you to take the initiative only if you wish to interact.

I have read, understood and agreed to the foregoing section: _____

PROFESSIONAL RECORDS

Documentation of sessions consists of a summary of each meeting and may include general issues addressed, possible symptom presentation or change, level of functioning, mental status, diagnosis and treatment plans. Federal regulations and Texas law requires that I maintain appropriate treatment records for at least 7 years from the last date of service. If the client is a minor child, I must maintain treatment records for 7 years from the date the child turns 18.

As a client, you have the right to obtain a copy of your records upon submission of a written authorization. The records of your treatment will contain confidential information about you. Texas law requires that all requests to review or obtain copies of your records must be made in writing. In my practice, I require that clients sign an appropriate authorization before I release any records to them.

I have determined that a reasonable, cost-based charge for providing you with a copy of your records will be $25.00 for the first 20 pages, then $ .50 cents per page thereafter, plus actual costs of shipping or mailing. Generally, I am not required to provide copies of requested records until the fee is paid.

I have read, understood and agreed to the foregoing section: _____

LIMITS ON CONFIDENTIALITY

In general, the privacy of all communications between you and a therapist is protected by law, and I can only release information about our work to others outside your relationship with your written permission. But there are a few exceptions outlined below:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your written authorization. However, if your records are subpoenaed or if a judge issues a court order for your records, I am legally obligated to comply.
2. If I believe that you are a danger to yourself or to other persons, I will contact medical or law enforcement personnel.
3. If you disclose information that leads me to suspect that a minor, elderly, or disabled person is being abused or neglected, I am required by law to notify authorities and I will comply with this requirement.
4. If you file a lawsuit or a complaint against me for any reason related to your therapy, I am allowed to use confidential information to defend myself.
5. If a court order or other legal proceeding or statute requires disclosure of your information, I will obey the court order or the law.
6. If you waive the rights to privilege or give written authorization to disclose information, I will comply with your authorization.
7. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy.

Insurance companies require a clinical diagnosis to reimburse for treatment. Some may require additional clinical information to support payment. Information collected by an insurance company will become part of the company's files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. Medical data has been also reported to be legally accessed by enforcement and other agencies, which may place you in a vulnerable position. The safest way to protect confidentiality is to pay cash for treatment. If you elect to use your insurance coverage to pay for treatment, I will assume that you have evaluated the stated risks and elected to proceed.

By your signature below, you acknowledge that you have been advised of these limits to confidentiality and potential risks.

I have read, understood and agreed to the foregoing section: _____

PLAN FOR PRACTICE IN CASE OF DEATH OR DISABILITY

In the event of my death, incapacity, or disability, I have made arrangements for another psychotherapist to take over my practice, assume control of my records, meet with clients, make appropriate referrals to other providers, if necessary, and take all

reasonable steps to manage the practice for the benefit of my clients. By your signature below, you authorize my designee to contact you directly, and use and disclose your confidential mental health information and records for the stated purposes.

I have read, understood and agreed to the foregoing section: _____

COMPLAINTS

You have a right to have your complaints heard and resolved in a timely manner. If we cannot work things out to your satisfaction you may inform your insurance carrier and file a complaint with them or with my licensing board: Texas State Board of Social Worker Examiners, Complaint Management and Investigative Section, P. O. Box 141369, Austin, Texas 78714-1369, (800) 942-5540. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

I have read, understood and agreed to the foregoing section: _____

Please Initial

_____ I understand the nature of the proposed therapeutic treatment and I give my informed consent for psychotherapeutic treatment by Terri Lively, LCSW.

_____ By my signature below, I acknowledge and agree that I am the parent, legal guardian, or Managing Conservator for the minor child(ren) listed below, and that I have the legal right to consent to psychotherapeutic treatment for said child(ren). I understand the nature of the proposed therapeutic treatment and I give my informed consent for therapy by Terri Lively, LCSW for my child(ren) whose name(s) are listed below:

_____

_____

_____ I understand that Terri Lively, LCSW will require a copy of the pertinent Divorce Decree or Court Order if the requested counseling is to involve a minor child whose parents are parties to a Suit Affecting the Parent Child Relationship in order to make sure that the parent bringing the child to therapy has the legal right to do so. I agree to provide the requested document(s) before Ms. Lively provides any services to the child. I understand that if I fail to provide Ms. Lively with these documents, she will refuse to see or provide services to the child.

_____ I understand that the fee for service is $150 per hour for each individual session, and for all other services related to counseling.

_____ I have also been informed regarding fees related to legal proceedings and Ms. Lively's litigation policy. I agree to abide by that litigation policy. If I choose to involve Ms. Lively in my legal proceeding, I agree to pay the fees set forth in this agreement, and I further agree not to contest any of those fees that are charged to my credit card on file.

_____ I understand that the counseling session is 50 minutes in length.

_____ I agree to pay $75.00 for missed appointments or appointments that I cancel less than 24 hours in advance. I understand that insurance companies do not pay or reimburse for missed appointment fees. I understand that to avoid the $75.00 fee, I must give 24 hours advanced notice to cancel or reschedule an appointment.

_____ I understand that if I am experiencing a medical or mental health emergency, I have been advised to dial 911 or go to nearest emergency room, and I agree to abide by these instructions.

I have read the above Agreement carefully, I understand the terms of this Agreement and I agree to comply with them. I understand that this Agreement is a contract between me and Terri Lively, LCSW and may be legally enforced as a written contract. I agree that this Agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated AFTER the date of this Agreement and must be provided to Ms. Lively. I agree that a copy of this Agreement has the same force and effect as the original.

_____ _____

Signature of Client or Parent Date Signed

_____

Printed Name of Client

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