CLIENT INFORMATION AND CONSENT

Therapist

The undersigned therapist is a licensed professional therapist engaged in private practice providing mental health care services to clients directly and as an independent contractor/ provider for various managed care entities.

Mental Health 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 and 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 972-235-9205, Monday through Friday between the hours of 9:00 A.M. and 5:00 P.M. Please call to cancel or reschedule at least 24 hours in advance, or **you will be charged a $50.00 missed appointment fee.** Third-party payments will not usually cover or reimburse for missed appointments.

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 45 minutes in length, but may take longer for psychological testing.

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 be your friend or 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.

Goals, Purposes, and Techniques of Therapy

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting goals of your therapy. As therapy progresses, these may change. The initial goals, purposes, and techniques of therapy agreed upon by you and the therapist are as follows:

_____

_____

_____

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise *you* will be charged a **$50.00 missed appointment fee**. You are responsible for calling to cancel or reschedule your appointment.

Payment for Services

The charge for you initial session is _____ and the charge for any subsequent sessions is _____. The undersigned therapist does not normally accept assignment of insurance benefits but may be required to do so in connection with certain managed care contracts. **The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges.** Different co-payments are required by various group coverage plans. Your co-payment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the co-pay may be different for the first visit than for subsequent visits. You are responsible for and shall pay your co-pay portion of the undersigned therapist's charges for services *at the time the services are provided.* It is recommended that you determine your co-payment before your first visit by calling you benefits office or insurance company.

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 the therapist's testimony are requested by you or 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. The therapist may require a deposit for anticipated court appearances and preparation.

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; IDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, 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 a licensing board or other state or federal regulatory authority. **FOR FURTHER INFORMATION, REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THE CLIENT INFORMATION AND CONSENT DOCUMENT.** If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this 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 with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to Warn

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

NAME **TELEPHONE NUMBER**

_____

_____

_____

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization shall expire upon the termination of my therapy with the undersigned therapist.

I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that I have received and reviewed.

I acknowledge that I have been advised by the undersigned therapist of the potential of the redisclosure of my protected health information by the authorized recipients and that it will not longer be protected by the federal Privacy Rule.

I further acknowledge that the treatment provided to me by the undersigned therapist was conditioned on my providing this authorization.

Contact Information

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

NAME **TELEPHONE NUMBER**

ADDRESS

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 sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both of our parts and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

After-Hours Emergencies

Emergencies are urgent issues requiring immediate action. In the event of a mental health emergency, call 911 or go to the nearest emergency room.

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. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional. The appointed possessor of my file will be Dr. Kim Rockwell-Evans PhD, located in the same suite as Cynthia Hutchins. That address is 375 Municipal Drive, Suite 230, Richardson, TX 75080. Dr. Evans office telephone number is 972-368-6999.

Consent to Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services and authorize the undersigned therapist 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 at any time.

By signing the 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 Date

As witnessed by:

_____ _____

Cynthia Hutchins, MS, LPC Date

I acknowledge that I received a copy of this signed intake and consent form from my therapist on this _____ day of _____, 20____.

_____

Client