Debbie Reinhardt Counseling, LCSW, LLC (TX License # 17200)

10935 Estate Lane, Suite 453 Dallas, TX 75238 972-818-5358

Informed Consent

Contract for Services and Treatment

This contract is a reciprocal agreement with corresponding rights and responsibilities on both sides.

STATEMENTS OF UNDERSTANDING

I have chosen to receive services by a Debbie Reinhardt, LCSW, LLC. My choice is voluntary. I understand that I may terminate therapy at any time. I understand that there is no guarantee that I will feel better because psychotherapy is a cooperative effort between my therapist and myself. I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during my course of treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems. For example, a history of trauma or abuse may be discussed. With therapy there are possible side effects and some risks are involved. Therapy is often emotional and draining for the individual and things may appear to get worse before they get better. Anxiety and fear may result from dealing with and facing emotional issues. Relationships may change as you make changes in your personal life and gain increased self-awareness and understanding. As a result of your therapy sessions, your provider may recommend you to a psychiatrist to evaluate the need for medication. Clinicians at Southwest Psychotherapy Associates do not prescribe medications.

_____ Initials

THE COUNSELING RELATIONSHIP

All social workers (hereafter referred to as providers) are required to adhere to the Code of Ethics and Standards of Practice as put forth by the Texas State Board of Social Work Examiners. This code precludes dual relationships in order to protect the rights of clients and maintain the objectivity and professional judgment of the provider of services. In the event that a relationship outside the therapeutic relationship is unavoidable, the provider of services will discuss the situation with the client and resolve the issue with the client professionally and in a manner most suitable to the client's needs and best interests.

_____ Initials

LEGAL DUTIES

State and federal laws require that your medical records are kept private. Such laws require that you are provided with this notice informing you of our privacy of information policies, your rights, and our uties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to us in an evaluation, intake, or therapy session(s) are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements or confidentiality and privacy of records.

_____Initials

LIMITS OF CONFIDENTIALITY

While HIPAA and the Right to Privacy Act bind all providers of Mental Health Services, there are limitations. Some specific limitations of confidentiality are:

-When the client waives their right to privacy and written consent is provided,

-When disclosure is required to prevent clear and imminent danger to the client or others,

-When a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

-When ordered by an official of the court as required by law, -Information required by insurance companies for payment (for which you need to provide written consent), -Information provided to parents if the client is a minor.

- Professional misconduct by a mental health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

-Valid collection of a debt, and/or

-Consultation with other professional is order to aid in the treatment process (identifying information will be withheld unless written permission is given).

-Information about you may be used by personnel associated with this practice for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as other therapists affiliated with this practice, such as your individual, family and group therapist; and business associates affiliated with this practice such as billing, quality enhancement, training, audits, and accreditation. Release of information to other individuals, agencies, or professionals may only be done with your written consent. Laws have been enacted for your privacy. It is important to know that emails, text, and phone call interchange, including text messaging are not secure or guaranteed for privacy because they can potentially be intercepted. Therefore, by signing this document you understand that if we have correspondence by email, phone/text, or Skype there is a potential for confidentiality to be compromised.

_____Initials

FINANCIAL ARRANGEMENTS

The rate for the initial session, the diagnostic interview, is $175.00. The rate for subsequent, 50 minute sessions is $120.00, for private pay. You may pay by cash, check, or Zelle. The client (or parent/guardian) is responsible for payment of all fees. Payment in full for all professional services is due at the time of the service. The fee for less than 24 hour notice cancellation and no show appointments is the same as the total session fee. Checks should be made payable to: Debbie Reinhardt. It is helpful to have checks made out prior to the session. Returned checks are subject to a $35 service fee which must be paid prior to the next appointment, and future payments will be required to be made with cash or money order. Because payment is due when services are rendered, I usually do not send bills. If, however, a situation necessitated that you be billed, please remit payment within five days of receiving the invoice. If any account goes unpaid, a service charge of 1.5% will be added. 18% APR will be added to all overdue accounts. The client will also be liable for all legal and collection fees. For clients working with Networks, please contact their customer service line, regarding payment.

_____ Initials

INSURANCE

Your health insurance policy is a contract between you and your insurance company. Should you choose to use your insurance, you may be eligible for “out of network” benefits, but you will need to research your coverage to make this determination. You are responsible for

completing and filing the necessary paperwork for insurance reimbursement in such a situation. I will provide you a receipt for services rendered. Please let me know if you intend to access your insurance benefits as additional information, such as a specific diagnosis, is usually required. You are also responsible for keeping track of your benefit requirements/limitations such as the number of sessions allowed per calendar year, authorized time periods, and so on. Should you choose insurance as an option, I may be required to provide the company with your personal health information, which includes history as well, for you to be reimbursed. You must give written permission for the release of your personal health information. Please be aware I have no control or responsibility for confidential procedures employed by your insurance company. For clients dealing with a network, please contact the customer service line for paperwork and/or questions regarding billing.

_____ Initials

APPOINTMENTS & COURSE OF TREATMENT

Appointment duration, times, and frequency will be determined based on the individual needs of the client. Generally, appointments will last 50 minutes for individuals, couples and families, and group times vary. Being late for an appointment by 20 minutes or more may require that you reschedule. The session will end at the scheduled time, regardless of late start, unless the late start is at the fault of the therapist. The duration of therapy will be determined by client progress, the desired goals of the intervention, treatment type, and mutual agreement between the provider and the client. Upon termination of therapy the provider will assist the client in finding other services or another therapist, when necessary. Closure is an important part of the therapeutic relationship for both the provider and the client. For this reason we encourage a termination appointment for all clients that are ending individual therapy.

_____ Initials

CLIENT RIGHTS

You have the right to request or receive your medical records. The procedures for obtaining a copy your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our addresses on file, you must provide this information in writing with a signature. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This

request must be made to us in writing with a signature. You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. This request must be made to us in writing with a signature. If you desire a written copy of this notice, you may obtain it by requesting it in writing.

_____ Initials

The terms and conditions of this contract can be renegotiated upon the request of the client and/or the provider (with client approval) at any time.

_____ Initials

If at any time the client has a problem or complaint against the provider, the client may grieve directly to the Texas State Board of Social Work Examiners- Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540.

I, _____, have read and understand the (Client Signature or Parent/Guardian signature if client is minor) above guidelines of the informed consent. I have been given the opportunity to ask questions and have been informed of the rights if confidentiality and my rights as a client. I understand that the contract for services portion of this contract can be renegotiated at any time by my request or consent. I agree to the treatment, procedures, and goals of therapy as discussed with the provider. I have received a copy of the informed consent and the contract for services.

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Client Name (Please Print)

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Client Signature or Parent/Guardian Signature if client is a minor Date