R & R COUNSELING & CONSULTING
SERVICES, PLLC

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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. If you decide that you do not wish to consent to these services and policies and, therefore, would not like to proceed with services here, there will be no charge for our meeting today.

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 endeavor 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 and distorted beliefs, whereas relational 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 large 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, I will typically schedule therapy sessions 50 minutes duration for one session and up to 60-90 minutes for a family therapy session at mutually agreeable interval. When an appointment hour is scheduled, you will be expected to pay for the session unless you provide 24 hours advance notice of cancellation, except in the case of a personal emergency. 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.

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 written 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 caregivers attend is something that can be negotiated at the outset of treatment and can be adjusted as needed.

For minor clients who are between 16-17 years of age, it is my policy to request an agreement from the patient and his/her parents that the parents' consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their

child's treatment when it is complete. Any other communication will require the child's consent, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

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. My first rule is 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. Also, I do not allow step-parents to make therapy appointments for child clients unless the child's parents have signed an Authorization allowing the step-parent to schedule the child's appointments

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

TERMINATION OF TREATMENT

I hope we will mutually agree about when you have met your treatment goals, so we can schedule final sessions to review your progress and develop a plan to help protect your relationship 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 either of 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 request and authorize it in writing, 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.

If you choose to involve the legal system in our work together by issuing a subpoena for my treatment records or my testimony in court, this will represent a conflict of interest for me, and I will terminate our therapeutic relationship and provide referrals to other providers.

In addition, if you schedule a session and do not attend the session or call me within 7 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

Sam Robison contracts with Child Protective Services (CPS) and accepts insurance only in relation to this specific contract arrangement.

For all non-contracted services (CPS), the hourly fee for a single individual therapy session with Samuel Robison or Heather Robison is $125. The hourly fee for a family therapy session is $200. In addition to therapy appointments, I may charge my standard $125 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 15 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.

Some insurance companies may reimburse part of your therapy expenses if you have out-of-network coverage for behavioral or mental health. Upon request, I am happy to provide you with a receipt that you can include when filing an insurance claim with your insurance company. Out-of-network reimbursement is often contingent on receiving a medical or mental health diagnosis and certain diagnoses may not qualify. I do not accept responsibility for collecting payment from your insurance company and cannot guarantee that you will be reimbursed or that you will qualify for a reimbursable diagnosis. Please contact your insurance provider to find out if you have out-of-network coverage and bring any necessary forms to your first appointment.

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

LITIGATION POLICY AND FEES FOR COURT-RELATED SERVICES

I do not want to be involved in your litigation. I do not want to sacrifice professional time I could be providing needed counseling services to manage subpoenas or lawyers or having to disclose your confidential information in court. I do not enjoy going to court and I do not want to deal with the negative feelings that can result from court or deposition testimony. The nature of the therapeutic process often involves making a full disclosure with regard to many matters which may be extremely private, upsetting or embarrassing. 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 with lawfully issued subpoenas. **My hourly charge for all time related to court cases or litigation is $300 . 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 the time I must spend dealing with 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 Williamson County, I will charge an hourly fee of $300 per hour for a minimum of 4 hours $1200 and this includes preparation time, travel time, and attendance at any legal proceeding. If I am required to testify in court or give a deposition outside of Williamson County, the hourly fee will be $300 for a minimum of 6 hours $1800. If the testimony or deposition exceeds 4 hours (in Williamson County) or 6 hours (outside Williamson County), there will be an additional charge of $300 per hour for every hour spent in court or deposition.

When I go to court or give a deposition, I have to clear my schedule and not see other clients, so there is a 48-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 **NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES**. 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 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 provide medication or medical advice. I will NOT provide legal advice. These services are NOT within the scope of my practice.

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

BILLING AND PAYMENTS

You will be expected to pay 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, or credit card (Visa, MasterCard, American Express or Discover). If any amount remains unpaid, no additional sessions will be scheduled until the balance is paid in full.

If you are not a client being served under CPS or another formal contract you are responsible for full payment of my fees. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

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

CONTACTING ME

Other than session attendance, the only way I may be contacted is by the office phone, 512-806-6696. My office hours vary and I am often not immediately available by telephone.

I routinely return calls within 12-24 hours during regular business hours, Monday through Friday, 9:00 a.m. to 5:00 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 Williamson County 24/7 Crisis Hotline at **1-800-841-1255.** 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

E-mail is for scheduling matters only. I do not use e-mail with clients regarding clinical matters. If you need to discuss a clinical matter between sessions please call me. If you choose not to respect my policy regarding e-mail communications, I will take steps to block further e-mail communications. I also reserve the right to terminate therapy and refer you to other providers. Any e-mails you send to me will be printed and will become part of your clinical record.

I do not text with clients. If a text is sent to my telephone number, it will be deleted without being read. All clients should contact me by telephone for any substantive matter relating to their therapy. Use of e-mail is allowed for administrative purposes.

I do not allow audiotaping of sessions unless we have agreed otherwise in advance and you have signed a specific written authorization for the taping to occur. For this reason, I request that you turn your phone off when you enter my office. I reserve the right to confirm that your telephone is off, or request that you leave your telephone in your car. If you refuse to confirm your phone is off, or if you refuse to leave your phone in your car when requested to do so, I will cancel the session. We can then discuss whether to reschedule the

session or terminate our therapeutic relationship. If the decision is to terminate, I will confirm the termination in writing and include referrals to other providers. By your signature below, you acknowledge that you understand my policy on the audio taping of sessions and you agree to abide by it.

I do not engage in communication or relationships via social media with clients. This is for the protection of your privacy as well as the therapy relationship. If you happen to encounter me by accident through social media or the internet please feel free to discuss this with me in session. I do not accept "friend" requests from current or former clients on my psychotherapy related profiles on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

I would never post information about a client on a public website. I ask that you respect my privacy and refrain from posting any "reviews" or other information regarding my practice or me on any website such as HealthGrades, Angie's List, or other forum for posting public reviews of health care providers. By your signature below, you agree that you will not post any "review" or any other information on any website without my prior written permission. If I believe that you have violated this agreement, I reserve the right to terminate our professional relationship immediately and refer you to other mental health professionals.

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 if you would prefer to do so.

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. Texas law requires that I maintain appropriate treatment records for at least 5 years from the last date of

service. If the client is a minor child, I must maintain treatment records for 5 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.

Records of therapy can be misinterpreted and/or can be upsetting to lay readers. If you request a copy of your records, I will provide them to you within 15 days of receiving the request unless I believe that to do so would endanger your life or the life of another person. If I believe that I must withhold the records due to a situation involving life endangerment, I will write you a letter to explain my reasons for withholding the records and your options.

I have determined that a reasonable, cost-based charge for providing you with a copy of your records will be $.25 per page. 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. In the case of a subpoena, I will contact you so you (and/or your attorneys) can take steps to contest the subpoena. If you do nothing to contest the subpoena after being notified by me, I will obey the subpoena.
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 within 48 hours 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.
8. If I learn of previous sexual exploitation by a mental health provider I am required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider. The client has the right to remain anonymous when the report is filed.

Most 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.

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

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: The Texas State Board of Professional Examiners of Professional Counselors: 1-800-942-5540. 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 R & R Counseling and Consulting Services, PLLC.

_____ I understand that the fee for service is $125 for each individual

Session and $200 for each family therapy session. I have also been informed regarding fees related to legal proceedings and R & R Counseling and Consulting Services, PLLC's litigation policy and I agree to abide by it.

_____ I understand that the counseling session is **50 minutes** in length for individual therapy and 60 – 90 minutes in length for family therapy.

_____ I agree to pay the full for any missed appointments. To avoid a fee, please

give 24 hours advanced notice if you must 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 R & R Counseling and Consulting Services, PLLC 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 R & R Counseling and Consulting Services, PLLC. I agree that a copy of this Agreement has the same force and effect as a copy.

_____ _____

Signature of Client or Parent Date Signed

_____

Printed Name of Client