

Charissa Fry: Licensed Professional Counselor Intern

Supervisor: Tiffany Ashenfelter LPC-S

The Vale Counseling and Therapeutic Center

2862 N. Belt Line Rd. Sunnyvale, TX 75182

972-698-8478

Office Procedures and Disclosure Information

People entering counseling often feel anxious about the beginning of the process. This is partly due to the uncertainty of what will occur in session, what is expected of the client, what role the therapist will play, payment, and confidentiality. Please read the following information which was prepared to help you know what to expect. Please keep this information for future reference and feel free to ask questions concerning information at any time during the course of treatment. You must sign the Consent to Treatment on the last page before we begin treatment.

Therapy Sessions

At the end of our initial meeting we will discuss a general plan for continued therapy sessions if you or your family and I are in agreement to commit to a counseling relationship. There are no guaranteed outcomes in the process of psychotherapy. The results of your counseling experience will depend on our interpersonal relationship and your motivation and efforts toward honesty, self-reflection, openness, and desire to change.

I will approach the counseling process from a Christian and Biblical worldview. However, I work with people of all faiths and encourage spirituality as an important part of the therapeutic process. As part of the counseling process you may experience challenging and painful emotions including anger, sadness, anxiety, and so on. These emotional responses are a natural result of the process of reducing distressing symptoms, life change, increased insight and control in life, healthier relationships, and a deeper spiritual walk. I am available to walk through this process of change and all difficult emotions and decisions that accompany progress. You have the right to ask questions to gain information on any aspect of the counseling process. Additionally, you have the right to withdraw from treatment at any time and ask for referrals.

Confidentiality

One of the most important and unique aspects of the client/therapist relationship is confidentiality. I will not disclose any information about you without your explicit request. The law also recognizes the special confidential nature of the client/therapist relationship. However, the law requires that I must release information in the following situations: 1) If I have a reason to suspect child, spousal, or elder abuse, 2) If I am aware that you become a danger to yourself or others.

Additionally, as I am under supervision, I am required to share information about our sessions with my supervisor. However, the supervisor is required to maintain confidentiality concerning your information as well.

Emergencies

This office does not provide 24 hours phone coverage and all after-hours phone messages will be returned the next business day (excluding Fridays when the office is closed). If you need to reach me prior to our next scheduled appointment, please call the counseling center during office hours to speak with the Administrative Assistant. I will return your call within 24 hours, Monday through Thursday. If you require emergency services, please call 911.

Fees and Insurance

Payment is required at the time of the session for the current session and all additional services provided in between appointments. We accept checks, cash, and credit cards. If you are unable to pay the fee at each session, please discuss your difficulty with the counselor to discuss a payment plan.

If you choose to submit claims for psychological services to your medical insurance company, you will need to meet the criteria for an official diagnosis. This diagnosis, basic information about you including goals, progress, and treatment plans will be required by the insurance company and may become a permanent part of your medical records. The confidentiality of your information cannot be guaranteed once it is sent to the insurance company.

Cancellations

We require 24 hours notice to cancel an appointment. If you give less than 24 hours notice, you may be charged for the session. We understand emergencies may arise that do not allow you to give 24 hours notice, in these cases, the counselor may not require payment.

Consent to Treatment

I have received a copy of the **Office Procedures and Disclosure Information**. I consent to psychological services for myself (and/or for my child).

I understand that during counseling, issues may be discussed that could be upsetting in nature but that this would be a part of the therapeutic process. I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults. I understand that state and local laws require that my therapist report all cases in which there exists a danger to others or myself. I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand if I have a managed care insurance plan that offers reimbursement to The Vale Counseling and Therapeutic Center, I must indicate that at the time I complete my initial paperwork, and call my insurance company to authorize sessions to cover therapy. If I have traditional insurance, I understand it is my responsibility to file for reimbursement, The Vale Counseling and Therapeutic Center will supply a receipt that will have the necessary information needed to process the claim. I agree to pay my counseling fees as arranged at the time of my first session in a timely manner. Should a third party other than insurance agree to pay for my sessions, I agree to allow The Vale Counseling and Therapeutic Center to release billing information to the third party.

I have read and understand the above conditions of my treatment and agree to their content.

Signature _____

Date _____

Client Name _____

Client Name

Last

First

Middle

Three Goals for Treatment (Specific Desired Outcomes)

1. _____

2. _____

3. _____

Male Female Married Single Student Child

Client(s) Age Client(s) Birth Date Phone #1 Phone #2 Email Address(es)

Home Address _____

Place of Employment _____

Emergency Contact – Name/Address/Phone (If client is under 18, please list contact info for all legal guardians.) _____

Client's Physician – Name/Address/Phone _____

Medical Conditions/Hospitalizations (Dates of Admission/Discharge/Reason) _____

Prior and Current Medications – Drugs/Dates/Reason _____

Current Alcohol and Drug Use – Frequency/Amount _____

Previous Counseling or Psychotherapy or Evaluation – Professional's Name/Dates/Reason _____

Have you experienced any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Self Harm | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Change in Weight |
| <input type="checkbox"/> Suicide Attempts | <input type="checkbox"/> Unemployment | <input type="checkbox"/> Major Illness/Injury |
| <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Change in Sleep | <input type="checkbox"/> Violent or Troubling Behavior |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Death of Loved One | <input type="checkbox"/> Change in Appetite | |