

Henn & Peoples
Licensed Professional Counselors
1120 Nasa Pkwy, Ste 305
Houston, Texas 77058

Consent to Treatment

Counseling is a "process" of *healing, growth, and change* that is dependent on my involvement/participation. It involves taking responsibility for deciding what I am willing to change or do differently in my life. It will be necessary to collaborate or work with my therapist to develop a "treatment plan" that will assist me in achieving my goal.

Making a commitment to a "treatment plan" of action is critical to my success in counseling. My role as a client, is to decide what my goal is or what I want to accomplish. Together, we will formulate a plan for change (treatment plan). It will require persistence and willingness on my part.

My counselor's/therapist's role is to provide a safe and therapeutic environment that will facilitate change and help to reduce painful symptoms that I may be experiencing. I am aware that sometimes stronger and new feelings emerge as I "work through" certain issues in my life. This is part of the process of healing, growth, and change. It requires that I practice new thoughts, feelings, and behaviors.

I am aware that my therapist will challenge, confront, explore, and encourage new thoughts, feelings, and actions that will facilitate the accomplishment of my goal. There will be no judgment of what direction I choose or advice giving by my therapist.

Specific "homework" assignments will be given between sessions that I am agreeable to. I will consult with my therapist before terminating treatment to discuss any dissatisfaction or reason for termination if it is before a mutually agreeable time to terminate.

I do hereby seek and consent to collaborate with my therapist in the counseling process. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest.

I understand that no promises have been made to me as to the results of treatment. Further, I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received, even those that may be denied by my insurance company.

APPOINTMENTS and FEES

I am aware that my appointment time is reserved especially for me. I agree to give 24 hours notice of appointment cancellation and pay a \$50 fee if I do not provide this courtesy. Each appointment will be no more than 50 minutes in length. The regular fee for service is \$120 for an initial and \$100 for follow up sessions. Group therapy sessions are \$50. I understand that my therapist may have a contract with my insurance company that covers a portion of the fee with a copayment that I am responsible for. I understand that I am responsible for any balance due that my insurance company does not pay.

I am aware that an agent of my insurance company or other third-party payer and my therapist may be given information about the type(s), cost(s), and dates of services that I receive. I understand that if payment for the services I receive here is not made, my therapist may stop my treatment.

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CONFIDENTIALITY

The therapist named below will make every effort to protect your confidentiality regarding the content of therapy sessions and records which is required by law and professional ethics, with the following exceptions:

- I give my written permission to share information with a third party
- If there is suspected child abuse and the client presents a danger to self or others
- If the therapy record is subpoenaed by a court of law
- If the parents of a minor client request information

DISABILITY

Should I apply for disability services through my employer or otherwise, I understand that my therapist does not write letters, recommend, or complete disability paperwork.

COURT

I understand that my therapist not a willing participant in court cases. I am aware that should I be involved in a lawsuit and my therapist or therapy records are subpoenaed, I will be charged \$100 per hour (minimum of 4 hours or \$400) for my therapist's time. This includes travel time, preparation of therapy records (including the writing of a summary letter), and her time in court.

I understand that if, for any reason, I am not satisfied with my therapist's counseling practices I may file a complaint with: The Texas Board of Examiners of Professional Counselors in Austin, Texas; 512-834-6789.

My signature below shows that I understand and agree with all of these statements and consent to treatment ___ for my child to enter treatment with Donna Henn, M.S., LPC. ___ Patti Peoples, M.S., LPC

Printed Name

Signature of or for client

Date

I have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date

This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited by law.
