Corporate Family Counseling, PLLC
2717 Commercial Center Blvd
Suite E-200 Katy, TX 77494

# INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES AND CONTRACT FOR SERVICES

**This Informed Consent for Psychotherapy Services and Contract for Services ("Agreement") is a legally binding, enforceable agreement between _____ (hereinafter referred to as "Client", "You/you" or "Your/your") and Corporate Family Counseling, PLLC ("Therapist") as of _____ ("Effective Date").**

**1. Confidentiality.**
All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure are described in the HIPAA Notice of Privacy Practices.

**2. Preventing Harm.**
Disclosure is required by law in situations in which (1) there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and (2) a client presents a danger to self, to others, to property, or is gravely disabled**.** If there is an incident during or after the course of treatment in which Therapist becomes concerned about your safety or the possibility of your harming another, Therapist will take reasonable measures within the limits of the law to ensure the safety of yourself and others. For this purpose, Therapist may also contact the person whose name you have listed as an emergency contact.

**3. Legal Proceedings & Litigation Limitation.**
Disclosure *may* be required pursuant to a legal proceeding. (For example, if you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Therapist.) Due to the private nature of psychotherapy, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, your attorney, nor anyone else acting on your behalf will call on Therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

**4. Family Involvement.**
In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Therapist will not release records to an outside party unless Therapist is authorized to do so by all adult family members who were part of the treatment.

**5. Confidentiality of E-mail, Cell Phone and Fax Communications.**
E-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication cannot be guaranteed.

**6. Consultation.**
Therapist may consult with other professionals regarding his clients; however, the name of Client name or other identifying information is never mentioned. The identity of Client identity remains completely anonymous, and confidentiality is fully maintained.

**7. Chance Encounters.**
Given that Katy, Texas is a relatively small community, Client may encounter someone Client knows in the waiting room or cross paths with Therapist out in the community. Therapist will never acknowledge working with Client therapeutically to anyone without Client's written permission. If Client sees Therapist in a public place, Therapist will acknowledge Client only if Client initiates the interaction, so as to maintain your confidentiality. Please respect the privacy of other clients you may recognize in the waiting room or outside the office by not sharing with others your knowledge of their therapy participation.

**8. The Therapy Process.**

Therapist utilizes therapy approaches that involve collaboration. Your active participation is a pivotal factor in your progress. Effective participation on the part of Client includes expressing yourself honestly, being open to feedback, questioning ideas that you disagree with or do not understand, and implementing new strategies discussed in therapy. It is Therapist's responsibility to listen carefully to you, share Therapist's observations, share Therapist's observations and insights related to your situation, and provide education on current perspectives from psychology research and practice, and connect you with additional resources that may be helpful (such as books, support groups, etc.). Therapist will collaborate with you at the end of each session to design "homework" assignment(s) to further the work begun in your therapy sessions. This is a key component of the therapy process, and your progress will reflect how actively you implement new strategies during time between sessions.

**9. Discussion of Treatment Plan.**

Within a reasonable period of time after the initiation of treatment, Therapist will discuss with you Therapist's working understanding of the problem, treatment plan, therapeutic objectives, and Therapist's view of the possible outcomes of treatment. Therapist will answer any questions you may have about procedures used in the course of your therapy, Therapist's expertise in employing them, or their possible risks. You may also ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Therapist does not provide, Therapist has an ethical obligation to assist you in obtaining those treatments. During the course of therapy, Therapist is likely to draw on various psychological approaches based on Therapist's expertise and Therapist's assessment of what will best benefit you. A variety of approaches may be incorporated.

**10. Outcomes.**

There is no guarantee that psychotherapy will yield positive or intended results. Change will sometimes be easy and swift, but other times it may seem slow and even frustrating. During therapy, exploring unpleasant events, feelings, or thoughts can result in your experiencing considerable negative reactions such as anger, sadness, worry, fear, anxiety, depression, and insomnia. Such reactions should be discussed with Therapist and monitored closely. Progress should be assessed and treatment goals established by mutual consent. If adequate progress is not seen, you and Therapist should discuss the treatment process and evaluate whether a different direction should be considered.

**11. Ending Therapy.**

If at any time during treatment Therapist assesses that Therapist cannot be effective in helping you reach your therapeutic goals, Therapist will provide multiple referrals to resources that may be of help to you. If you wish, Therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you wish to consult with another therapist, Therapist can assist you in finding someone else who is also qualified. You have the right to end therapy at any time. It is strongly advised that you discuss ending treatment with Therapist before doing so, in order to process the transition in the most effective way possible. At the close of therapy, Therapist will offer to provide you referrals for additional resources for continuing personal development.

**12. Telephone & Emergency Coverage.**

If you need to contact Michael Hack, LCSW in between sessions please call: +1-832-529-6001. Your call will be returned as soon as possible. Voice messages will be retrieved continually. For emergencies, call 911. When Therapist is out of town, coverage by another therapist will be arranged.

**13. Fees, Payments & Insurance Reimbursement.**

a. Fees. Client agrees and shall pay CFC the standard initial Biological, Psychological, Social Inventory & Assessment fee of US$350.00 at the time this Agreement is signed. Client agrees and shall pay CFC subsequent session fees of US$250.00 ("Session Fee") prior to each session beginning. Services provided outside of these sessions (e.g., telephone conversations, report writing, consultation with other professionals) will be charged at the same rate if such charges are agreed upon in advance by Therapist and Client.

b. Insurance Reimbursement. If you intend to utilize your health insurance, professional services are rendered and charged to Client, and not to the insurance companies, and due and payable according to the terms described above in this paragraph. Therapist can provide you with a monthly medical invoice, which you may then submit to your insurance company for reimbursement. Please note that not all issues which are the focus of psychotherapy, are reimbursed by insurance companies and it is Client's responsibility to verify the specifics of Client's coverage.

c. Credit Card Processing Fees. Should Client choose to pay any Session Fee with a credit card, a Four Percent (4%) credit card processing fee will be added to the Session Fee.
d. Late Fees and Collections. Client agrees and shall pay a late fee of $25.00 per month, and/or $50.00 for any returned checks. Also, should CFC be required to hire an attorney in connection with collection of any fees due and owing under this Agreement, Client shall pay CFC's reasonable attorneys' fees and expenses in connection with such efforts

**14. Appointment Cancellation.**

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours' notice is required for rescheduling or canceling an appointment. Client agrees that Client shall pay the Session Fee for missed sessions or late cancellations.

**15. Governing Law and Jurisdiction.**

This Agreement shall be governed by applicable federal law and the laws of the State of Texas. All claims and disputes of any nature relating to or arising under this Agreement, including any performance of duties relating to or arising under this Agreement, shall be litigated in the courts of Houston, Harris County, Texas.

Please initial each of the following statements to indicate your agreement and print/sign your name below.

__I have read the above Agreement and agree to comply with its terms.

_____ I understand that I am responsible to pay for missed sessions that are not cancelled with at least 48 hours' notice and that insurance companies do not reimburse for missed sessions.

__I have received the Health Insurance Portability and Accountability Act (HIPAA) notice and I consent to the use or disclosure of my Protected Health Information as specified.

_____

**Client name (print)**

_____ _____

**Signature** **Date**