Plano Counseling Solutions

CONSENT FOR TREATMENT

MISSION:
PLANO COUNSELING SOLUTIONS is dedicated to helping individuals, couples, and families to heal, grow and change. We help clients in stopping the frustration, anxiety, sadness, and emotional pain they are experiencing by providing counseling sessions in a professional manner.

TREATMENT:
Services are provided following discussion with the prospective client and/or the referring physician. Clients should be aware that psychotherapy may produce internal changes, and clients often experience a surge of intense feelings during the course of treatment. Clients should be aware of this potential stress upon themselves and their relationships. In addition, there is no guarantee that treatment will be successful, as individuals respond differently to therapeutic approaches. PLANO COUNSELING SOLUTIONS offers a wide range of behavioral health services but, in some cases, other clinical providers, medical professionals, hospitals, or community service centers may assist in treatment. Treatment duration and frequency will vary depending upon the presenting problems. Your therapist will discuss with you in the first two sessions what your therapeutic goals and prospective course of treatment will be. As therapy progresses, clients may choose to alter these goals or add new ones.

CONSENT FOR TREATMENT:
I acknowledge that I have received and have read (or have had read to me) and understood the therapy I may engage in, and I have had all my questions answered fully.

I do hereby seek and consent to take part in treatment through PLANO COUNSELING SOLUTIONS.

I understand and agree that no promises have been made to me as to the results of treatment or of any procedures provided by the therapist.

I am aware that I may stop my treatment with my therapist at PLANO COUNSELING SOUTIONS at any time. I understand and agree that I may lose other services or may have to deal with other problems if I stop treatment before goals are attained. (For example, if my doctor has directed my treatment, I will have to answer to him/her and/or the insurance payer regarding my self-termination of treatment).

I understand and agree that I must call to cancel an appointment at least 24 hours before the appointment. If I do not cancel my appointment at least 24 hours beforehand - or do not show up for the appointment – my treating doctor and/or insurance payer will be advised.

I understand and agree that, **if I do not cancel an appointment at least 24 hours ahead – or do not show for the appointment – I will be assessed a $80 no show fee.** I understand that the fee must be paid before another appointment will be scheduled.

7800 Preston Road, Suite #117, Plano TX 75024, Phone 972-743-4674

I understand and agree that payment for my treatment is due at every session, in the amount of ____ for a 45-50 minute session. I understand and agree that, if payment for the services I receive here is not made, the PLANO COUNSELING SOLUTIONS therapist may stop my treatment and make outside referral as necessary.

I understand that PLANO COUNSELING SOLUTIONS accepts payment by MasterCard/Visa Credit/Debit Card, personal check, or exact cash.

I understand and agree that, if my check is returned by my bank for insufficient funds (NSF), I will have to pay a $40 returned check fee before my next appointment and replace the funds the NSF check was originally written for. In addition, I understand and agree that my personal checks will no longer be accepted as a form of payment for my treatment at PLANO COUNSELING SOLUTIONS.

I understand and agree to inform my therapist at PLANO COUNSELING SOLUTIONS of any changes to my insurance coverage while I am in therapy.

I understand and agree that I am personally responsible for the cost of the services rendered to me, including but not limited to: all co-pays, unmet yearly deductibles charged by insurance provider, any fees or portions of fees not paid by my insurance carrier and that PLANO COUNSELING SOLUTIONS cannot legally or ethically waive them at any time.

I understand and agree that payment for any services rendered that are funded by my insurance policy will be assigned from me to PLANO COUNSELING SOLUTIONS as my form of payment for services rendered. I permit a copy of the signature on this release to serve as a lifetime authorization. A copy of this release may be used in place of the original. Furthermore, failure to keep payments current by insurance will result in collection action for the balance due.

I understand and agree that my doctor, an agent of my insurance company, other third-party payer, or my legal representative may be given information about the type(s), cost(s), date(s), and provider(s) of any services or treatments I receive and will be given reports containing information about my progress and participation in treatment from PLANO COUNSELING SOLUTIONS.

I understand and agree that I will not receive copies of my progress notes from PLANO COUNSELING SOLUTIONS if it is suspected that the information obtained could prove harmful to me. I understand and agree that I will not receive copies of my progress notes from PLANO COUNSELING SOLUTIONS unless reviewed between a clinician and myself and to do so will warrant scheduling an appointment.

I understand and agree that in family/group therapy settings, individual privacies are maintained to the best extent possible.

I agree that I will leave my cell phone, pager, and any other two-way communication device in the “off” or “silent” mode during counseling sessions.

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I understand and agree that information about myself, including case records, will be released under the following conditions:

1. The PLANO COUNSELING SOLUTIONS therapist is using case records for purposes of supervision, professional development, or training and research. In such cases, to preserve confidentiality, clients will be identified by first names only;
2. The PLANO COUNSELING SOLUTIONS therapist determines that the client is a danger to himself/herself or to someone else;
3. The client discloses abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. The client discloses sexual contact with another mental health professional with whom the client has had a professional relationship;
5. The PLANO COUNSELING SOLUTIONS therapist is ordered by a court to disclose information;
6. The client directs the PLANO COUNSELING SOLUTIONS therapist to release the client's records;
7. The PLANO COUNSELING SOLUTIONS therapist is otherwise required by law to disclose information.

I understand and agree that, should I have a complaint regarding any of the treatment that I receive through PLANO COUNSELING SOLUTIONS, I may inform the therapist that I am working with. If I wish to go beyond this level of complaint, I may advise my treating physician and/or insurance provider and/or contact the State Board of Examiners for Licensed Professional Counselors at 1-800-942-5540.

I agree that a photocopy or fax transmission of this form is acceptable, but that it must be individually signed by me. I understand that I have a right to receive a copy of this form upon my request.

_____ _____

Patient/Client Signature Date

_____ _____

Patient/Parent/Guardian Signature Date