**Full Circle Therapy Center, PLLC
Nicole Siegel, LCSW, LCDC**

**Practice Policies and Informed Consent**

Welcome and thank you for choosing Full Circle Therapy Center, PLLC as your provider for counseling services. This form will provide you with information regarding what to expect in the counseling process, practice policies, privacy practices, emergency protocols and professional fees.

**Therapeutic Relationship**

While working together, sessions will last approximately 50-55 minutes. Initially, an evaluation that will last at least two sessions will be conducted. Following the period of evaluation, the client will be consulted regarding therapist feedback, diagnostic impressions and recommendations. The client will be asked to participate in the treatment planning process including goals for treatment and concerns. The therapist will check in with the client periodically regarding the pace of treatment, goals achieved and the client’s satisfaction regarding the course of treatment. It is likely there will be recommendations for the client to perform homework or reading assignments outside of counseling sessions. While it is not required, it is more likely the client will see improvements in his/her condition if active participation is demonstrated.

**Therapeutic Process**

To preserve the efficacy of the therapeutic process, the relationship between client and therapist is one of a professional nature. Our contact will be limited to counseling sessions either in person, via phone or web therapy. Appointments may be scheduled, cancelled or rescheduled by phone. Text messaging and email communication is allowed *only* for the purpose of scheduling or cancelling appointments. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, invite me to join you on social networking sites, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will best be served if our sessions concentrate exclusively on your concerns.

Psychotherapy can have benefits and risks. Since therapy involves discussing uncomfortable aspects of your life, this may lead to uncomfortable feelings. However, part of counseling is learning how to deal with these feelings in new and better way. There is the potential opportunity for changes to take place in your life surrounding, relationships, jobs and/or a new understanding of yourself. These changes could be perceived at any given time as negative or positive. The nature of these changes cannot be predicted. Together we will work together to achieve the best possible results for you.

**Client Rights**

At any time, you may initiate a discussion of possible negative or positive effects of entering, not entering, continuing or discontinuing counseling. However, I do ask that you participate in a termination session. You have the right to refuse or discuss any treatment methods which you might believe to be harmful. I assure you that my services will be rendered in a professional manner consistent with the accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If a resolution cannot be found, an appropriate referral to a new provider may be given at any time.

If you have any complaints you may contact the following:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

or call 1-800-942-5540 to request the appropriate form or obtain more information.

**Other Providers**

It is recommended; if you have participated in psychotherapy with other providers (ie. individual counselors, treatment centers or hospitals) that you sign a release of information allowing the exchange of information between providers to better coordinate services. It is required, if you have consented to treatment with Full Circle Therapy Center PLLC, then you will not consent to psychotherapy with other providers simultaneously. If you decide to maintain or establish a professional relationship with another mental health provider against my advice, I may consider this your decision to change counselors and reserve the right to terminate your counseling.

I also reserve the right to postpone and/or terminate counseling of clients who come to sessions under the influence of alcohol or drugs.

**Professional Fees**

Diagnostic and Evaluation Session (1st visit)- $175.00

Regular Office Visit/phone or telehealth session (50-55 minutes)- $150.00

Regular Office Visit/phone or telehealth session (85 minutes)- $225.00

Regular Office Visit (1 hour and 50 minutes)- 300.00

Phone calls- $37.50 per each 15 minute increment.

Fees for other services such as documentation, providing medical records, attending court, transportation or any other service provided outside of the allotted session time may incur a fee. A list of these fees may be furnished upon request and may be found in this form.

**Payment of Fees**

Required fees and co-pays are payable at the beginning of each session.  We will honor contractual agreements made with managed health care/EAP companies which stipulate specific reimbursement restrictions and claim filing requirements. However, if you are using a managed care plan, you will be expected to pay your copay at the beginning of the session. Due to the increasing problem with obtaining accurate benefit information from managed care companies, it is sometimes necessary for us to collect the full contract rate for the first couple sessions until we receive the first insurance Explanation of Benefits (EOB) & payment. Once benefits are established, we will apply any overage to future copayments, or you can be reimbursed for any overpayment. If you are using your insurance benefits, Full Circle Therapy Center, PLLC will file claims if requested. However, we do not file secondary insurance. If you are not using a Managed Care/PPO/HMO plan and want to file your own claim, you will be expected to make the full payment and a superbill will be given for you. Please understand you are responsible for any and all fees for services rendered. Full payment is required at the time services are rendered. Furthermore, treatment may be suspended and/or terminated if payment is not received. You understand you will be responsible for all bank fees associated with returned checks. If you choose to file out-of-network insurance then no sliding scale will be available. We accept all major credit cards, Health Savings cards, check, and cash. Receipts will be given upon request.

**Cancellation Policy and Account Balance**

In the event that you will not be able to keep an appointment, please call at least 24 hours in advance or the card on file will be charged a No-Show/Late Cancellation fee of $75.00 per session, $112.50 for an 85 minute session and $150.00 for a 1 hour and 50 minute session.

It is the client’s responsibility to leave notice of cancellation on our voice mail, which will note the day & time you called. Your communication with our office about appointment cancellations allows us to offer that time to other clients who need to be seen.

**Court appearances, letters and other paperwork**

Therapist requires proper service of subpoenas to appear in court/deposition. A faxed subpoena will not be accepted. Regardless of who makes the request, client is responsible for any and all costs incurred for subpoenaed deposition, court appearance, and/or documents. Court appearances are billed at $250.00 per hour with a minimum charge of eight (8) hours, for a total of two-thousand ($2,000.00) dollars. In such cases as the therapist is ordered to testify by the court about her counseling with you, the therapist will be monetarily compensated as below. In the event, that it is necessary for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for her own legal representation, services, including travel, preparation, and necessary expenditures at the rate of $250.00 per hour, rounded to the nearest half hour. These expenditures include but are not limited to copies, parking, meals and the like. Regardless of actual appearance, payment for services will be made through a NON-REFUNDABLE $2,000.00 retainer two weeks prior to the appearance, presentation of records, or testimony requested. All additional expenditures will be billed after the court appearance. Client agrees to schedule expert testimony and court appearances as far in advance as possible in order to avoid conflict in the therapist’s schedule; such conflicts will be reflected in the amount charged by the therapist.

Other letters and paperwork requested by the client will be assessed a charge of $100.00 per hour, rounded to the nearest hour, with a minimum 1 hour charge. This does include letters to court officials or attorneys, short-term disability paperwork and any other documentation requested by the client. This does not include copies of your bill, missed work or school letters, Release of Information forms, nor any other documents used in the day-to-day operations of the office. Requests for medical records will be assessed a charge of $25.00 (first 20 pages) and .25 for each additional page.

**Emergencies**

Please call and express the nature and urgency of the emergency on the voicemail. Due to the fact that clients are scheduled one after another, it is not always possible to get a message or return a call immediately, but all effort is made to do so in emergency situations. If an after hour or weekend emergency occurs, you may leave a voicemail but if you cannot wait for a return call and need immediate assistance please dial 911 and/or visit your nearest hospital emergency room. Other helpful numbers to contact include; the Crisis Intervention 24-Hr Hotline at (817) 927-5544 in Tarrant Co. and (214) 233-2233 for adults in Dallas Co. or (214) 233-TEEN for teenagers.

**Death or Incapacity of Therapist**

In the unfortunate event that your therapist becomes unable to continue to see you due to disability or death, by your signature below you are giving permission to the office coordinator and another licensed therapist to briefly review your file for the purpose of notifying you and possibly transferring you to another appropriate therapist. If this is unacceptable for any reason, notify the office coordinator or therapist before signing this document. Also, in the unfortunate event of your death, what becomes of your file may become an issue. It is possible that several people will want us to release information from it or even turn it over to them. It is in your best interest, as well as that of your family, and the professionals within this office, for you to tell us in advance to whom you **would** permit us to release information, **without** having a court order. You can choose to not give permission to anyone but if you want to permit one or more people, please list them on

the following lines by full name and relationship, i.e. spouse, grown son/daughter, sibling, etc.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Records and Confidentiality**

Texas law protects the privacy of communications between a client and your clinician. Every effort will be made to keep your evaluation and treatment strictly confidential. In most situations we will only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements.

In the following situations, authorization is not required:

 a) Clinical information about your case may be shared fully with support staff for purposes of supervision where applicable. If case information is presented at professional conferences, the information will be disguised so that it is impossible to link the information to you or your family.

b) Personal information is also shared for administrative purposes such as scheduling, billing, and quality assurance. Client files are also available to insurance company auditors. Data contained in your file is available for archival research (i.e., reviews of records to describe referrals, outcomes, and trends) as long as your identity cannot be linked to the data used. All staff members have been given training about protecting your privacy and have agreed not to disclose any information without authorization or approval by your clinician in mandated reporting situations (see Limits to Confidentiality).

c) Please note that your counselor may use a “Practice Management Provider” this is a 3rd party where your digital file is kept and stored. The company that is utilized is HIPAA compliant.

d) On occasion, your clinician may find it helpful to consult with another health or mental health professional. During such a consultation, every effort is made to avoid revealing the identity of the client. The other professional is legally bound to keep the information confidential. If you do not object, it is our policy to tell you about such consultations only if it is important to you and your clinician working together. All consultations are noted in the client’s record.

e) Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.

Any and all of our communication may become part of the clinical record. Although I will keep anything you say to me strictly confidential, there are legal exceptions as follows:

1. You authorize a release of information with your signature
2. I determine that you present a danger to yourself or others
3. I am ordered by a court to disclose information
4. You disclose sexual contact with another health professional
5. You disclose to me knowledge or founded suspicion of ongoing child or elder abuse
6. Use of a 3rd party billing (insurance) or scheduling provider
7. If the therapist receives supervision and/or consultation (collaborative approach to meeting clinical needs) in order to provide you with the best quality care

If participating in couples counseling, do not disclose anything to me that you do not want revealed to your partner, as this puts me in a compromising position. Furthermore, I do encouraged open communication between family members and should I determine any secret be detrimental to the therapeutic process, I do reserve the right to terminate our counseling relationship.

A record is kept of your work with us. It contains information you have provided to us in writing as well as counseling notes of your sessions. Full Circle Therapy Center, PLLC stores this record for a period of seven years following your last visit; after that time it is destroyed.

**Special Populations/Circumstances**

**Young Adults**

If a patient is considered to be a young adult or adult living at home, in some cases, I have found it helpful to include other members of the household in the patient’s treatment. In the event, the patient meets this special circumstance, the patient may be asked by therapist, to consent to allow communication with member(s) of the household. The patient reserves the right to confidentiality and the right to discontinue treatment if this policy is not acceptable to the patient.

**Release of Information**

I authorize release of information to my primary care physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit and administration and other purposes related to my health plan.

**Consent to Treatment**

By your signature below, you are indicating:

I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given the opportunity to address any questions, or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive a mental health assessment, treatment and services for me (or for a minor if I am the legally authorized representative (LAR) and I understand that I may discontinue services at any time.

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Signature- Client/Parent or Guardian Date

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Signature- Therapist Date