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INFORMED CONSENT AND PRACTICE POLICIES

QUALIFICATIONS: I have a Master of Science (M.S.) in Clinical Mental Health Counseling from Tarleton State University. I am a Licensed Professional Counselor-Associate and a Licensed Chemical Dependency Counselor (LCDC). My licensures and certifications qualify me to provide counseling and psychological assessment services independently. My formal education and training have prepared me to counsel individual adults, couples, and groups with a variety of concerns.

EXPERIENCE: I have counseled adults, couples, families, and facilitated many types of groups. I have experience and professional training in using Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and Polyvagal Therapy. Additionally, I have professional training in neuro and biofeedback and the Hakomi Method. My experience alos allows me to administer, score, and interpret a variety of behavioral assessments.

NATURE OF COUNSELING: My counseling is from an Adlerian viewpoint, based in individual psychology. I believe that people continually strive to overcome feelings of inferiority and toward wholeness and connection. My hope for you, the client, is that you will discover your true potential through an increased sense of identity, self-worth, support and confidence. We will collaborate on setting goals for treatment and appropriate interventions based on the issues brought to counseling, and any changes you may experience through growth and awareness will always be your decision.

Our first session will consist of an intake, which will give you the opportunity to tell me your history, how you are currently experiencing a need/desire for counseling, and to determine if we can work effectively with one another. After the intake, I will provide you a treatment plan, which will act as a guide for how we work together to help you reach identified goals.

COUNSELING RELATIONSHIP: The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding of how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. I do not discriminate based on age, racial or ethnic identity, gender identity, religion or spirituality, national origin, ability status, or sexual/affectional orientation. If significant differences, such

as in culture or belief system, exist between us, I will work to understand those differences. Feel free to discuss any of this with me at any time during your counseling journey.

THE THERAPEUTIC PROCESS: You have taken a brave step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong reactions of anger, depression, anxiety, etc. This is not miracle work. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and the repeating patterns that may not support your recovery goals, as well as to help you clarify what it is that you want for yourself.

CONFIDENTIALITY: The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client-held privilege of confidentiality exist and are itemized below, according to Texas State Law:

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person or a person with a disability who may be subjected to these abuses and/or neglect.
5. The client discloses sexual contact with another mental health professional with whom the client had/has a professional relationship.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena OR if a client is in therapy or being treated by order of a court of law, or if the information is obtained for the purpose of rendering an expert's report to an attorney.

Due to the status of my provisional license, I am required to meet periodically with my designated LPC Supervisor. This is not for the purpose of sharing your confidential information, but rather how I am developing in the skills needed to support your success. Occasionally I may need to consult with other professionals, as well, in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in both contexts without using your name.

If we see each other outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize them. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

CLIENT FILES: Client files are kept on a HIPAA compliant practice management software. In the event that I am no longer able to perform my duties as a counselor, client files will be securely stored and kept confidential by my LPC-Supervisor, Megan Guidry, LPC-S. The client will be contacted and provided with referral.

In the event case management duties become necessary for your case, such as consultation, release of records, and referral gathering beyond general practice, I will bill for the time it takes to complete tasks at my hourly rate of $110. Please be aware that any and all records requests must be in writing and will not be completed without a release on file. I will not surrender hardcopy client files to anyone except the client on file. If you require a hardcopy of your client file, please request via email at least two weeks prior to when you need them. I am happy to send records to other mental health/medical professionals via registered postal mail, or a secure, digital means.

I am happy to provide a case summary for any court-related issues, however, I will not agree to appear in court to testify in divorce/custody disputes. The use of your therapy notes to provide evidence in court is not recommended or encouraged, as it may result in unfavorable outcomes for you, the client. If I am ordered to appear, I require payment for services five days in advance at the rate of $130/hour. These fees cover the unpredictable duration of court, travel, preparation, consultation, and appearances in court, and miscellaneous charges I may incur.

If I am not called to appear in court, these fees are still due. You, the client, are responsible for any fees I incur related to your case (litigation issues, lack of payment, parking, lodging, printing/copying materials, etc.). For the record, I will not agree to appear in court to testify on your behalf unless I am subpoenaed by a judge.

APPOINTMENTS, SERVICE FEES AND CANCELLATIONS: I am legally required to provide you with a Good Faith Estimate (GFE) for privately paid services. I will issue a GFE after I have done a thorough evaluation and have assessed for diagnosis, issues and treatment needs.

This will give you an idea of the range of costs/costs you can expect during your time receiving my services.

Appointments are typically scheduled weekly or every other week. I may suggest more or less frequent appointments dependent upon my clinical discernment and your preference.

Fees per session:

Psychotherapy 50 minutes: $110

Neuro/Biofeedback 50 minutes: $150

Alcohol/Other Substance Diagnostic Assessment 30 minutes: $50

I accept credit card, check and cash payments. If you prefer payment by check, please acknowledge that there is a $45 charge for all returned checks.

Fees are subject to change annually and you will be notified at least 30 days in advance of any change in fee.

Payment for Services: You understand that the fee agreement is a legally binding contract and that you are under obligation to pay for services provided to me at the time of the session or prior to, and that the fee agreement is valid while receiving services and may be renegotiated pursuant to business costs. You understand that failure to pay for services rendered within the negotiated time frame may result in legal action.

Insurance Billing: If you have a health insurance policy, it will usually provide coverage for mental health treatment. Currently, I am not a participating provider for any insurance plan, but I will supply you with a super bill for services, upon request, which you can submit to your insurance company for potential reimbursement.

**Please note that not all insurance companies reimburse for out-of-network providers.

Cancellations and re-scheduled sessions will be subject to a full charge if **not received at least 24 hours in advance**, and the credit card on file will be charged. This is necessary because a time commitment is made to you and is held exclusively for you.

You may cancel/reschedule by phone call (please leave a VM), text, or email. When texting, please identify yourself by first name only.

Your collaboration regarding the punctuality of starting and ending sessions at the appointed times will be appreciated. If you are **15+ minutes late** for a session and have not notified me of the reason you are late, you will be considered a no-show and charged the full fee per session.

If you have been exposed to or are symptomatic of COVID-19, flu, or any other virus that is highly contagious, please do not come to the counseling office. You may request a telehealth session or cancel the session. Please do not reschedule until you have been fever-free for 48 hours.

TELEPHONE ACCESSIBILITY AND EMERGENCY CONTACTS: If you need to contact me between sessions, please attempt to call me first. Leave a message on my voicemail or send me a text message with your first name and "TALK."

I am often not immediately available; however, I will return your call as quickly as I can.

If a true emergency situation arises, please call 911 or go to your nearest emergency room.

OTHER LOCAL RESOURCES:

Pecan Valley Behavioral and Developmental Healthcare (Hood, Somervell, Erath, Johnson, Palo Pinto and Parker counties):

Mental Health 800-772-5987 Crisis Hotline and Intake Screening Line

1-866-948-7198 Intellectual and Developmental Disabilities Intake Line

Dial 988 for Suicide/Crisis Lifeline or text 838255.

SOCIAL MEDIA AND TELECOMMUNICATION: Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can discuss it further.

ELECTRONIC COMMUNICATION: I cannot ensure the confidentiality of any form of communication through electronic means, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:
That I have read or had this form read and/or had this form explained to me.
That I fully understand its contents including the risks and benefits of the procedure(s).
That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Please check below that you understand you will be expected to regularly attend your therapy appointments via telehealth:

☑ Telehealth

TERMINATION: You have the right to end our counseling relationship at any time. You also have the right to refuse or to discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the therapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating.

If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified clinicians to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued. You will receive a termination notice with referrals after the third week.

Acknowledgment of Receipt of Privacy Practice, Informed Consent, Agreement to Telehealth Services and Practice Policies:

This notice went into effect on May 29, 2025. I reserve the right to change the terms of this notice and will provide you with a revised notice when needed.

If you have any questions or would like additional information, please feel free to ask.

Please sign and date below. You may request a copy of this disclosure.

I have CAREFULLY read the Informed Consent, Agreement to Telehealth Services and Practice Policies, and have discussed with Jill E. Brown, M.S., LPC-Associate, LCDC any questions and/or concerns I have had regarding its content. I am willing to enter therapy under these conditions.

Printed Client Name: _____

Signature: _____ Date: _____