Claggett Counseling and Associates, PLLC
500 Turtle Cove Suite 220
Rockwall, Texas 75087
214-797-7221
dottieclaggett.com

CLIENT INFORMATION

Name: _____

Male ____ Female ____ DOB _____ AGE ____

Address: _____

City: _____ State: _____ Zip: _____

EMAIL: _____

Contact Phone Number_____

** By signing this form, you are giving us permission to contact you at the various addresses (including email, phone number and mailing address).

**The information you provide below is your authorization for me to contact these individuals should I deem it an emergency situation and/or necessary for your safety or the safety of others.

Emergency Contact: _____

Phone: _____

_____

Signature Date

Claggett Counseling and Associates, PLLC
Dottie Claggett, MA LPC-S License #18396
500 Turtle Cove Suite 220
Rockwall, TX 75087
Telephone: 214-797-7221

Informed Consent for Treatment

Client Name: _____

I, the client, request that Claggett Counseling and Associates, PLLC provide a behavioral health assessment and any counseling services applicable to me or minor child listed. If I am consenting to my minor child, I am also acknowledging that I am the custodial parent and have permission to make medical and psychological treatment decisions for my minor child.

Print Name of custodial parent: _____
Address of custodial parent: _____
Telephone # of custodial Parent: _____

If divorced or have Guardianship, I must provide copy of divorce degree/legal document pertaining to where it shows I have the right to make these decisions on behalf of my minor child

_____

Signature of Client or Guardian Date

Counseling

Counseling is an opportunity for healing and personal growth. We believe that individuals possess the ability to do what is necessary to take an active role in this process. Psychotherapy involves change, which may feel threatening not only to you but also to those people close to you. At times you may feel vulnerable as you face painful information and behaviors. At the same time, psychotherapy can aid you in discovering tools and techniques that you can use to improve the quality of your life and relationships. If the disclosure of past hurts or current struggles cause a temporary increase in depressive or anxious symptoms, please discuss the symptoms with your counselor ____(initial)

During the counseling process your counselor may recommend books for you to read, offer handouts, or use techniques to facilitate personal growth. We

encourage you to discuss with your counselor any approach, technique, or practice with which you have questions, concerns, or need clarification. Counseling can be a difficult experience for some people. If at any point, you wish to end therapy, you are free to do so. Additionally, if your counselor feels like a particular issue or topic is beyond the scope of their clinical training and/or believe you may benefit from clinical services from a different counselor, the counselor will take reasonable steps to facilitate your transfer to appropriate care.

At times, the counselor may need to consult with other professionals or agencies on the client's behalf. A client's signed consent to disclose information to other agencies and/or individuals will be required. Exceptions may include a subpoena by a court of law. If a client has received or is currently receiving mental health services and/or psychotropic medications from another health care provider, we may request that individual's consent to speak with those professionals and/or obtain copies of previous treatment records. Providing treatment may depend on our ability to communicate with these professionals. If a client is using insurance, it will be necessary to disclose limited diagnostic and treatment plan information to said insurance provider for the authorization of payment by third party payers. _____(initials)

The relationship that exits between a counselor and a client is professional rather than social. Therefore, contact with your counselor will only take place in the provision of a professional service. Your written consent is required to disclose any information about you or your family to individuals outside of Claggett Counseling and Associates, PLLC. In most cases, counseling is completely voluntary, and you can discuss ending your counseling relationship at any time. However, we recommend that, when possible, all counseling relationships be ended in an appropriate and therapeutic manner, generally requiring a final session to allow for closure.

Confidentiality & Record Keeping Practices

All communications between you and your counselor will be held in confidence in accordance with the law and professional standards of the Texas State Board of Professional Counselors and will not, except under the circumstances explained below, be disclosed to anyone without your written

prior authorization. Recording of counseling sessions by client, any Collateral Participant, or anyone associated with Claggett Counseling and Associates, PLLC is strictly prohibited without prior written consent of all parties present. Exceptions to confidentiality include, but may not be limited to, the following:

- Imminent harm to self or others, including information regarding any sexually transmitted diseases
- Suspicion of abuse or neglect of the elderly or disabled
- Suspicion of abuse (sexual or otherwise) or neglect of children
- Compliance with a court order to do so
- Child Custody case suits in which the mental health of a party is an issue
- Fee disputes between the therapist and the client
- A negligence suit brought by client against therapist or filing of a complaint with the licensing board
- Processing third party payor forms, obtaining payment for third party payors, answering required question from third party payors in order for client benefits to continue

Communications between a client and a counselor and records created or maintained by a counselor, are confidential. Confidentiality is described as keeping private the information shared between a client and his/her counselor. Counseling sessions here at our practice are strictly confidential. Subject to the below discussed exceptions, information regarding your counseling sessions will not be discussed without your permission, beyond the staff here at Claggett Counseling and Associates, PLLC. There are legal limits to confidentiality and times when a counselor or therapist is obligated to disclose pertinent information, as necessary, to the appropriate authorities, agencies, or individuals. Counselors are required to break confidentiality in instances of suspected or known child abuse, abuse to the elderly or disabled, or knowledge that a client is a danger to himself/herself or to someone else. Additionally, parents or legal guardians may have access to their minor child's records unless the minor is emancipated. Provisionally licensed counselors and/or therapists are required to discuss their cases with their supervisor. ____(initial)

In any of the previous situations the counselor must report the suspicion or knowledge of abuse to the proper licensing board or authorities. Additionally, court orders requiring the release of counseling records may result in the release of those records. In reference to the treatment of minors, risk-taking behavior that is considered detrimental to the safety of the minor or others will be shared with the minor's parent(s) and or guardian. _____(initial)

Participants who in couples and/or family counseling and are or become involved in individual counseling will have the discretion over their own information becoming a part of a counseling session involving other family members. Individuals involved in group counseling are required to maintain the confidentiality of the other group members outside of the group sessions. ____(initial)

Appointments

Counseling services are by appointment only. You are responsible for keeping your appointments and arriving on time. If you are late, your remaining time will be the length of your appointment.

I agree to pay for missed appointments unless I provide Claggett Counseling and Associates with notice of cancellation 24 hours in advance. I understand that the missed appointment will be noted on the bill, and that third party payers do not pay for missed appointments. The late cancellation fee will be charged at the regular session rate. ____(initial)

On-Line Counseling via Electronic Platforms

We attempt to protect your privacy by using a HIPAA compliant platform such as Doxyme. You are also free to use a regular phone call, Face to Face, email counseling but it is crucial to read the disclaimer. It is important that the user understands and agrees that the use of any or every part of the service is entirely at user's own risk and by choosing this type of service, no assumption of responsibility is made, or given, and the party requesting such advice agrees not to hold the counselor responsible or liable in any form or fashion, for such actions taken of their own accord. By signing this consent form, you are agreeing to the aforementioned statement. The Internet is an

insecure medium and users should be aware that there are inherent risks transmitting information across the Internet. Provider's services are provided "as is", without warranty of any kind, either express or implied, including without limitation any warranty or information services, counseling, uninterrupted access, or products or services provided through or in connection with the service. ____(initial)

By submitting your questions or intake information via email, Internet or fax, you are in agreement to pay for the concepts and insights received, whether it is deemed to be helpful or not. All sales are final. Responses will not be provided without payment. There will only be one response to each email. You are giving Claggett Counseling and Associates, PLLC access to your email address only for the purpose of replying to your question and/or to arrange for phone counseling, Doxyme, or Face to Face counseling/assessments. At any time, Claggett Counseling and Associates, PLLC reserves the right to terminate service if misleading information is given by the client. This on-line service is not a substitute for treatment for suicidal thinking, crisis, or severe psychiatric problems. Neither Claggett Counseling and Associates, PLLC nor any other party involved in creating, producing or maintaining any web site or email address associated with Claggett Counseling and Associates, PLLC or www.dottieclaggett.com shall be liable for any direct, incidental, consequential, indirect or punitive damages arising out of your access to, or use of, these sites or the information contained within. _____(initial)

Your email and responses are confidential. As in any face to face counseling, if there are threats to your safety, or the safety of others, child protective issues or suicidal or homicidal thoughts, proper authorities will be notified. These issues would override the issues of confidentiality.

Court Costs and additional requests outside of session times

If Claggett Counseling and Associates, PLLC and/or anyone associated is requested by me or subpoenaed by me or someone else to testify in any court related proceeding in which I am a party, I agree to pay Claggett Counseling and Associates, PLLC the following fees will apply:
This is per hour and minimum of one hour:

- $250.00 minimum- preparation time (including submission of records)

- $250,00 minimum-phone calls
- $250.00 minimum-Testimony in court
- $250.00 minimum-Depositions
- $250.00 minimum- time away from office due to deposition/testimony
- $125.00 minimum-preparation time for treatment summaries or production of other new documents.
- Mileage: $0.54 cents per mile
- $100.00- Filing a document with the court
- All attorney fees and costs incurred by the therapist as a result of the legal action**
- The minimum charge for a court appearance is a retainer of $2500.00 to be paid 48 hours prior to the court date. If the costs for testifying process exceed the amount of the retainer, then those fees will be billed to the client and/or their legal representative.
- $125.00/hr-For any subpoena of client records, files, or the production of any other written statements.
- Printing costs: $75.00 for first 20 pages and $0.50 cents per page thereafter.

All legal fees are due upon receipt of invoice.

_____ (client's signature)

Some clients need only a few sessions to achieve their goals, while others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any point. I will be supportive of that decision. If counseling is successful, you should feel that you are able to face life's challenges in the future without my support or intervention. I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Sessions are thirty or fifty minutes in duration. Please note that that it is. Please note that it is impossible to guarantee any specific results regarding your counseling, EMDR, or Neurofeedback goals. Together we will work to achieve the best possible results for you.

If you have any complaints, please discuss them with your counselor. If you are not satisfied with the resolution of the problem, you have the right to call the Complaints Management & Investigations (1-800-942-5540, or write

to Texas State Board of Professional Counselors, PO Box 141369, Austin, TX 78714.

The fee (125.00) for each counseling session will be due and must be paid at the beginning of each session. Cash, Master Card, Visa are preferred methods for payment. If you request a receipt, it can be provided when the fee is paid. In the event you will not be able to keep the appointment, you must notify me 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying for the session you missed. ____(initial)

Some health insurance companies will reimburse clients for my counseling services and some will not. Those that do reimburse usually require a standard amount to be paid by you before reimbursement is allowed, and then usually only a percentage of my fee is reimbursable. You should contact your insurance company to determine whether your insurance will reimburse you and what schedule of reimbursement will be used. You will be responsible for any amount not paid by your insurance company.

Health insurance companies often require that I diagnose your mental health and indicate that you have an "illness" before they will agree to reimburse you. In the event a diagnosis is required, I will inform you of the diagnosis I plan to render before I submit it to your insurance company. Any diagnosis made may become a part of your permanent insurance records. ___(initial)

Please be advised that I am an independent mental health provider. The other colleagues that occupy my office space (now and in the future) are not a part of the counseling practice identified as Claggett Counseling and Associates, PLLC unless otherwise specified.

I have had an opportunity to read this agreement and to have all my questions clarified. By signing this agreement, I affirm that I understand and agree without reservation to the provisions contained herein.

Client or Guardian Signature Date

PATIENT CONSENT FOR USE AND / OR DISCLOSURE OF Hipaa DEFINED PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby stated that by signing this Consent, I acknowledge and agree as follows:
:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice ("Information and Informed Consent") includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out her health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change her privacy practices that are described in her Privacy Notice, in accordance with applicable law.

understand and consent to the following means of contact as deemed professionally necessary by Provider:

Yes_____ No_____ Telephoning my cell phone and leaving a message on my voice mail

Yes_____No_____ Leaving a text message on my cell phone

Yes_____No_____ Leaving an email message at my email address

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice. Any of my questions have been answered to my full satisfaction.

_____

Client Signature **DATE**