

## **Informed Consent and Service Agreement Form**

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512-663-6368**

*Please read carefully and let me know if you have any questions before you sign or agree to the terms of this document.*

This document (the Agreement) contains important information about my professional services and business policies. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on this Agreement, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred with me.

### ***Counseling Relationship***

The counseling relationship is a professional process intended to help you resolve personal challenges, adapt to life changes, or explore your current life situation. Ways in which counseling can help you include: identifying goals and developing a plan to achieve these goals, overcoming or learning to live with a mental illness or disability, changing a behavior, or seeking support. I may employ a variety of educational and therapeutic techniques to help you achieve your personal counseling goals, and these may include out of session counseling exercises or homework. Some clients can accomplish a great deal in a short period of time. Those with complex issues or histories will require more time.

Therapy is often difficult and challenging work. One of the most important joint responsibilities is communication. It is important to take an active role in counseling, to be as open and honest as possible, to make appropriate efforts outside of sessions, and to feedback to me about how you think our counseling is going. If at any time during the therapeutic process you are dissatisfied with my services, please let me know immediately so that we can explore the problem together. If I feel that my services are not or will not be appropriate for you, or that our work is complete, I will discuss my concerns with you. I reserve the right to conclude our counseling work, or to refer you to a more appropriate provider, at any time. I will do so only after all necessary communication with you. Treatment is optional and not required and you have the right to terminate treatment at any time. I ask that you discuss your reasons for termination with me so that we can both learn from the counseling relationship.

### ***Multiple Relationships***

Austin, Round Rock and Georgetown are technically large cities. However, they are still small enough that there is a chance you will know one or more of my clients. You may "bump" into a friend, neighbor, employer, family member, colleague or business partner coming out of my office after his/her appointment. I do not acknowledge working with or even knowing any of my clients without his/her permission.

### ***Cancellations***

*I require 24 hours notice of any cancellation and will charge the full fee for missed appointments unless we both agree that you were unable to attend due to circumstances beyond your control.*  
Insurance companies typically do not reimburse for missed sessions. Failure to cancel an appointment may result in others not receiving the help they need and want. Your appointment times may be given to another client if you fail to come to an appointment. Please let me know if you need help remembering your appointment.

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### ***Contacting Me***

Due to my work schedule, I am often not immediately available by telephone and I do not answer the phone when I am with a client. When I am unavailable, you may leave a voicemail for me. I will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or one of the services listed below:

24-Hour Crisis Hotline 512-472-4357  
Psychiatric Emergency Services (PES) 454-3521  
Seton Shoal Creek Psychiatric Hospital 512-324-2000  
Brackenridge Hospital Emergency 512-324-7010  
General Emergency Number 911

If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

### ***Fees and Payment Policy***

#### ***Fees***

My basic fee is \$100.00 per 50-minute session and \$150.00 per 75-minute session. I charge \$100 per hour on a pro-rata basis for any other professional services you may need such as report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other services you may request of me. If you become involved in legal proceedings that require my participation, I expect you to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge twice my regular per hour fee for travel time, preparation and attendance at any legal proceeding and will require a retainer in advance of any work related to legal proceedings. I reserve the right to reassess my fee structure on an annual basis and will notify you ninety days in advance of any proposed increases or changes.

#### ***Insurance***

Please inquire about which insurance plans I accept. You are responsible for payment of all fees even if you plan to seek insurance reimbursement. If I do not take your insurance, I will give you a receipt so that you may file a health insurance claim. However, I do not guarantee your insurance company or other third-party payer will reimburse you, and I am not responsible for the collection of such payments. Sometimes, insurance companies or other third-party payers may consider certain services not reasonable or necessary, or may determine that services are not covered. In such cases, you are still responsible for payment of the services I have provided you.

#### ***Payment***

I expect you to make payment by check or cash at the time the services are provided. You will be responsible for returned check fees charged by banks. If your account becomes 60 days past due and arrangements for payment have not been agreed upon, I have the option of using a professional collection agency or small claims court to secure payment. Such action would involve disclosure of your name, the nature of the service provided, and the amount due.

#### ***Professional Records***

The laws and standards of my profession require that I keep treatment records. I will keep your records for at least seven (7) years past the date of your last visit. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can

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discuss the contents. I charge clients a fee for any professional time spent in responding to information requests.

### ***Confidentiality***

Psychotherapy, counseling, assessment, and associated services that are related to diagnosis, evaluation, and treatment services provided by licensed professionals are confidential and protected under Texas state law. The law protects the privacy of all communications between a client and a Licensed Professional Counselor (LPC). In most situations, I can only release information about your treatment to others if you sign a written authorization form. However, there are some situations where I am required by law to disclose information:

- If you report that a child, elderly person, or anyone else who cannot otherwise protect themselves has been or is being neglected, or physically or sexually abused;
- If you report that someone has been or is being neglected; physically or sexually abused; or subjected to illegal, unprofessional, or unethical conduct (including sexual exploitation) by a mental health professional;
- If you represent a harm to yourself; or
- If my records are subpoenaed by the courts for purposes of litigation.

I will also disclose information to the appropriate authorities if you represent harm to yourself or others. Should you seek insurance reimbursement for your counseling, disclosure of confidential information may be required to process your claims; I have no control over what the insurance company does with the information you have authorized me to release. I may occasionally find it helpful to consult other mental health professionals about a case. During a consultation, I make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. I will not tell you about these consultations unless if I feel it is important for our work together.

*Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.*

Client Name (PRINT): \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Name, if applicable (PRINT): \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Client if Legal Guardian \_\_\_\_\_

Counselor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Please sign one copy of this Agreement and keep a second copy for yourself.***