North Texas Counseling Associates

8090 Precinct Line Road, Suite 103
Colleyville, TX 76034
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INFORMED CONSENT AND RELEASE OF LIABILITY

Our goal is to provide you with quality counseling. Some clients need only a few sessions to achieve these goals while others may require many more. As a client, you have the right to end our counseling relationship at any point.

1. I understand that my counselor is working under Texas laws, rules and statutes as a Licensed Psychologist, Licensed Professional Counselor (LPC) or as a LPC-Intern under the supervision of Dr. Jennie Fincher, LPC-S.

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or the ethics of the counseling profession. Possible exceptions to confidentiality include but are not limited to the following situations:

- abuse of a child, elderly or disabled person
- potential harm or threat to self or others
- third party requests for payment
- child custody cases that go before a court of law
- information subpoenaed by a court of law

3. In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable North Texas Counseling Associates, PLLC, its employees or members from any and all claims, demands, actions, or causes of action of whatsoever kind and nature related to the counseling process. I also give permission for my counselor to converse with other counselors in the group practice to provide the best possible treatment.

4. The clinical records are the property of North Texas Counseling Associates, PLLC and are deemed records of confidential sessions between therapists and clients. I waive any right I may otherwise have to seek to use the clinical records of the counseling center as evidence in any judicial proceedings. I understand that if anyone from this office is subpoenaed or court ordered to testify in court as an expert witness, court fees are separate from the counselor's regular counseling rates. Court appearances, depositions, and attorney consultations are $150.00 per hour (including all time involved in preparation, research, parking fees, mileage, travel time to and from the court house and all other expenses incurred in relation to testifying). A retainer of $900.00 is to be paid prior to the court date. If the full amount of the retainer is not needed to complete the court testifying process, then the remainder of the funds will be refunded. If the costs for the testifying process exceed the amount of the retainer then those fees will be billed to you and are due upon receipt of the invoice. The party issuing the subpoena is responsible for the testifying fees.

5. Counseling sessions last approximately forty-five to fifty (45-50) minutes. It is the patient's responsibility to provide our office with the correct insurance information in order to file claims with the insurance company. Claims not paid due to incorrect information will then become the patient's responsibility. ***24-hour notice is required for all cancellations to avoid a $50.00 fee. If you fail to respond to commination for a late cancellation or missed appointment the card on file will be charged for the amount owed. If you are more than 15 minutes late for your appointment, you will be responsible for the $50.00 fee for the session. Any client that has more than 3 no show fees, late cancellation fees, or combination of both on account, individual forfeits future standing appointments*** Fees are due at the beginning of each session. *All accounts are required to have a credit card, non-dated check, or cash should a late cancellation/missed appointment occur on file to reserve future appointments.*

☐ Credit Card Number: _____ Exp. Date:_____

Billing Zip Code: _____ Type of Card: ☐ DC ☐ VISA ☐ MC

6. If at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance. We do not provide an on-call service at this time. You can also contact the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK).

Privacy Practice Notice:
The Notice of Privacy Practices for NTCA is provided upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills and the rights I have regarding my PHI.

I, the undersigned, consent to treatment and to North Texas Counseling Associates' Notice of Privacy Practices. My signature below indicates that I grant informed consent for North Texas Counseling Associates, PLLC to provide psychological services and counseling to myself and/or minor members of my family. I further understand that without 24-hour notice of cancellation, I will be charged $50.00.

Client/Guardian Signature: _____ Date: _____

Client Update Form

Today's Date:

GENERAL INFORMATION			
Name:	☐ M ☐ F	DOB:	Age:
Street Address:		Home Phone:	
City, State, Zip:		Cell Phone:	
Email:		Work Phone:	
Race: ☐ African-American ☐ Asian/Pacific Islander ☐ Caucasian/White ☐ Hispanic ☐ Native American ☐ Other:			
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
***Annual Household Income:**			

EMERGENCY CONTACT	
Name:	Relationship:
Home Phone:	Cell Phone:

Current Medications (List any prescription medications you are currently taking. Use back if necessary)					
Name of Drug	Reason for Taking It	Date Started	Frequency Taken	Strength	Has it been helpful?
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
Describe any side effects that you find troublesome from any of the medications you are currently taking.					
Do you generally take your medications as prescribed? ☐ Yes ☐ Take too much ☐ Don't always take					
What other psychiatric medications have you taken in the past?					

Mental Health/Substance Abuse Hospitalizations (Inpatient, PHP, IOP - Use back page if necessary.)				
Date	Reason for Treatment	Hospital	Duration of Treatment	Treatment Response (helpfulness)
Counseling/Therapy (Individual, Family, Group, Play Therapy - Use back page if necessary.)				

CURRENT STATUS

Please check any of the following that apply to you presently or in the recent past:

☐ Abortion
☐ Abuse, Physical
☐ Abuse, Sexual
☐ Abuse, Verbal
☐ Aggressive
☐ Alcohol/Drug Use
☐ Anger
☐ Anxiety
☐ Bad Dreams
☐ Career Choices
☐ Change in Appetite
☐ Children
☐ Communication
☐ Compulsivity
☐ Concentration
☐ Cutting/Self harm
☐ Difficulty Breathing
☐ Eating Problems
☐ Emotional Abuse
☐ Finances
☐ Friends
☐ Gambling
☐ Grief
☐ Guilt
☐ Headaches
☐ Hearing Noises/Voices
☐ Hopelessness
☐ Impulsive
☐ Inferior Feelings
☐ Legal Matters
☐ Loneliness
☐ Loss of energy
☐ Making Decisions
☐ Marriage
☐ Memory
☐ Nervousness
☐ Pain
☐ Panic
☐ Pregnancy
☐ Problems sleeping
☐ Racing Thoughts
☐ Rapid Heart Rate
☐ Recent Loss
☐ Seeing Things
☐ Self-Control
☐ Sexual addiction
☐ Sexual Problem
☐ Shyness
☐ Stress
☐ Stomach Trouble
☐ Tension
☐ Terminal Illness
☐ Trauma
☐ Trouble Relaxing
☐ Trouble with Job
☐ Unhappiness
☐Other_____