

INFORMED CONSENT TO MENTAL HEALTH SERVICES & CLIENT RIGHTS

Christy Mellen, MEd, LPC • 3560 Delaware, Suite 104 Beaumont, TX 77706 • p.409.899.4600/f.409.899.4606

Therapy is a joint effort between the therapist and the client, the result of which cannot be guaranteed. Progress depends on many factors, including motivation, effort and other life circumstances such as interactions with family, friends and other associates. The relationship between the therapist and client is the basis of the help that can be obtained in therapy. The following rights and responsibilities are offered as a foundation for the therapeutic relationship.

Client Rights & Confidentiality: All information disclosed within sessions is confidential and may not be revealed to anyone without your written permission except where disclosure is required by law or is a condition for reimbursement. For a minor, the custodial parent will have to sign the release of information. I will inform you whether or not I believe releasing that information might be harmful to you in any way. Individual therapy with children or adolescents requires special consideration in that the client's legal guardians may rightfully inquire about any treatment information; however, for the greater good of the youth, I request that parents/guardians be sensitive to the privacy that is needed for their youth to benefit from therapy. I may discuss general progress in treatment, but most information will remain confidential between me and your child. Disclosure may be required without your permission in the following circumstances: where there is a reasonable suspicion of child abuse or elder adult physical abuse, where there is a reasonable suspicion that the client presents a danger of violence to others, or where the client is likely to harm him/herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding such as therapy or evaluation by order of a court of law or in response to a legitimate subpoena.

Treatment Issues: A plan of treatment will be developed and this treatment plan will be discussed with you. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency situations. You have the right to ask questions about any of the procedures used in the course of your therapy or evaluation. You have the right to terminate the therapy or evaluation with the provider at any time without any financial, legal, or moral obligations other than those you have already incurred prior to termination. I will provide you with the names of other qualified professionals whose services you might prefer. Because of the nature of therapy, you may experience emotional strains and make life changes, which could be distressing. Telephone calls are primarily for scheduling appointments. Important therapeutic concerns should be brought into the session so they may be given the careful attention they deserve.

Emergency Procedure: If an emergency situation arises, please leave a message with pertinent information on the confidential voicemail; please note that phone calls are generally not returned on weekends or after business hours in the evening. Your call will only be returned when the counselor is out of session. Please state that your call is an emergency, and only do so with a true emergency. Otherwise please call -911 or go to the nearest emergency room.

Payment & Cancellations: Clients are expected to pay for services at the time they are rendered. Overdue accounts will be turned over to a collection agency. I understand that I will be responsible for court costs and legal fees necessary to collect on my bill. There will be a \$25.00 fee for checks drawn on uncollectible funds. Sessions are generally 45-50 minutes long and billed at **\$100.00 per session**. Since the scheduling of an appointment involves the reservation of time specifically for you and may involve holding appointments for other clients, a **minimum of 24-hours notice is required to reschedule or cancel an appointment**. Without adequate cancellation, the full fee may be charged directly to you for missed sessions without notification. _____ (Please Initial) We also reserve the right to discharge you as a client if you "**no show**" or "**same day cancel**", two or more times.

Consent to Evaluation & Treatment

After reading and understanding the rights and responsibilities above, I authorize, Christy Mellen, MEd, LPC, to carry out psychological examination and treatment procedures on myself and/or my child which now, or during the course of care, are advisable and for which I am legally responsible.

Client's Signature & Date

Therapist's Signature & Date

Parent or Legal Representative & Date

Other Signature (optional)