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INFORMED CONSENT

Please read, initial each item, and sign at the end stating you have fully read and understand the information below.

_____ **CLIENT/THERAPIST RELATIONSHIP**: You and I have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

_____ **AVAILABLE SERVICES:** Marie Denise Guillory, LPC offers a wide array of counseling services, including individual, family, couples, and group services. I am a skilled and experienced licensed professional counselor. Effective psychotherapy is founded on mutual understanding and good rapport between you, the client, and I. It is my intent to convey the policies and procedures used in my practice, and I will be pleased to discuss any questions or concerns you may have.

_____ **RISKS AND BENEFITS**: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

_____ **COUNSELING**: I provide counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which you and I will discuss your concerns, and if both parties agree that I can meet your therapeutic needs, we will develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you, services to you may be terminated.

My goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and I are not a good fit, please discuss this matter with me to determine if transferring to a more suitable therapist is right for you. If you and I decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide my clients with an integrated solution for their mind, body, spirit, and life, to enhance their lives and resolve issues.

_____ **APPOINTMENTS**: Appointments are typically scheduled on a weekly basis and are 45 – 55 minutes long depending on your insurance coverage. The allotted time includes counseling, payment, and the scheduling of our next appointment. More frequent sessions or an intensive outpatient schedule are available if I determined it is appropriate.

_____ **APPOINTMENT REMINDERS:** Although our system sends appointment reminders as a convenience, it should not be relied on 100% due to potential failure with electronic delivery. It is <u>your responsibility</u> to manage your appointments.

_____ **PHONE CALLS**: If you need to get in touch with me, please call 806.939.5673. If you are unable to reach me by phone, and you are in a crisis situation, please call 911 or go to the nearest hospital for treatment. If your call is not an emergency, feel free to leave a message and contact number, as my voice mail is confidential. I retrieve all messages personally.

_____ **CANCELLATION/RESCHEDULE**: If you must cancel or reschedule your appointment, we ask that you call our office at 806.939.5673 at 24 hours or more in advance. This will free your appointment time for another client. **The full session fee will be required for any cancellation/reschedule not made prior to the 24-hour time frame. Additionally, if you have a repeating appointment and cancel 3 times in a row, your repeating appointment will be removed and you will be rescheduled based on availability.**

_____ **MISSED APPOINTMENTS:** Failure to keep a scheduled appointment that was not cancelled or rescheduled prior to the 24 hour window is considered a "No Show". No Shows will be charged **The full session fee**

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$ 150.00
	Regular Office Visits (Standard Counseling Hour 45-55 min) (Individuals, Couples, family)	$ 150.00
	Crisis Office Visit (Counseling Hour 45-55 min)	$ 225.00
	Psychological or Educational Testing	Varies by Test
	Court Appearance Day 1	$2000.00
	(each additional day)	$ 900.00
	Written Reports (Insurance Companies, Supervisors, Disability, etc.)	$ 150.00
	Returned check fee per check	$ 25.00

A reasonable fee will be charged for copies of any records requested by the Client.

_____ **PAYMENT/INSURANCE FILING:** Payment of fees, including any required co-pays, is expected at the beginning of each session. This will allow the maximum amount of time to be spent on counseling and not on the payment. I accept payment in the form of cash, check, debit or credit. When using checks, make them payable to Marie D. Guillory, LPC. All checks that are returned for insufficient funds will be charged an additional $25.00 bank and handling fee. When using debit or credit, there is an additional fee to cover the cost of processing.

If you are using insurance benefits, my office will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered.

_____ **OVERDUE ACCOUNTS**: Payments not received within 30 days are charged a late fee of $5.00 per month. If payment is not received within 90 days, or monthly payments are not made as agreed, Marie D. Guillory, LPC will submit the account to the small claims court. The patient or responsible party is responsible for the charges incurred to collect the balance of the account.

_____ **EMERGENCIES**: In the event you encounter a personal emergency that will require prompt attention during my office hours, please contact my office regarding the nature and urgency of the circumstances. Either my office manager or I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

_____ **COURT APPEARANCE**: If I am subpoenaed for a court appearance I must have two week's prior notice to make arrangements and reschedule other client appointments. My rate for a court appearance is $2000.00 for the first day, and $900.00, for each successive day. This allows for one day of preparation work as well as actual court time. Even if the court time is one hour, the full rate will apply for my scheduling preparation and actual court appearance time. Additionally, any travel expenses or extra preparation charges will also be added, if necessary. Payment for a court appearance must be made one week **prior** to the court date and **is non-refundable, even if the hearing is cancelled.**

_____ **SOCIAL MEDIA**: I do not accept friend requests from current or former clients. This holds true for Facebook, LinkedIn, Snap Chat, TikTok, FaceTime or any other networking sites. My reasons for this stance are that I believe that adding clients as friends can compromise confidentiality and blur the boundaries of our therapeutic relationship. If you have questions about this, please feel free to bring it up in session.

_____ **ELECTRONIC COMMUNICATION:** Although they add convenience and expedite communication, it is very important to be aware that communication by any electronic means (Texting via Cell Phones, email, Texting via other methods, etc.) can potentially be accessed by unauthorized persons and hence can compromise the privacy and confidentiality of such communication. Unencrypted emails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited access to all emails that go through them. Therefore, if you are going to send me confidential information, please send it to me via encrypted-email.

Text messages are not encrypted. Although this form of electronic communication is great for cancellations and reschedules, I prefer you contact my office via telephone call.

If you communicate confidential or private information via any electronic communication, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted. However, due to the risks I will NOT provide counseling services via Text messaging, or email.

Please do not use Text. Email or Fax for emergencies. These forms of communication are not real-time and I may not check my Phone Email or Faxes until the next business day. Also, due to potential computer, network, Cellular, or fax machines/line problems, your message may not be deliverable. Phone is the preferred method for emergencies. If I am unavailable, please call 911 or go to your nearest emergency rooml.

If email communication outside of therapy requires more than 5 minutes to read or respond to, I may charge my full professional fee. Please indicate if you intend to pay these charges in your e-mail, or I will save it for review during your next session. Please DO NOT send forwarded messages regardless of how inspirational they may seem to my professional e-mail address. I use this for work related issues and do not want to risk viruses spread by forwarded e-mails. This also applies to Text messages.

_____ **CONFIDENTIALITY:** I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to my attention and we will discuss this matter further. By signing this Information and Consent Form, you are giving me consent to share confidential information with all persons mandated by law and with the agency that referred you, the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding me harmless from any departure from your right of confidentiality that may result.

_____ **RECORDS:** Your file is kept under my locked personal supervision. Your file includes your intake form, case notes of each session, this Informed Consent form, Client Information, testing results, copies of EOB, and any other written communications you might give me. State and Federal (HIPAA) laws will dictate all record protection.

_____ **DUTY TO WARN/DUTY TO PROTECT**: If Marie D. Guillory, LPC believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Marie D. Guillory, LPC to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to Marie D. Guillory, LPC to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
_____	_____
_____	_____

_____ **INCAPACITY OR DEATH**: I understand that, in the event of the death or incapacitation of Marie D. Guillory, LPC, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by Marie D. Guillory, LPC, to take possession of my records and/or deliver those records to another therapist of my choosing.

In the event of my death or incapacitation, you will be able to request your records through this office. My office manager will be glad to send them to your next provider. In the event of the death of my office manager, Staci Rocha, LPC will submit your records to your next provider. She can be reached at 806.787.0701.

_____ **TELEHEALTH OVERVIEW AND CLIENT UNDERSTANDING**: Telehealth is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

_____ I understand that Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment when I am located at a site different from my therapist.

_____ I agree to be in a secure, non-public, location during my Telehealth sessions.

_____ I understand my therapist will advise me of the Telehealth platform being used and will provide me with the link used to establish connection.

_____ I understand I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

_____ I understand that Telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100 % guaranteed to be secure.

_____ I understand that there are risks unique and specific to Telehealth, including but not limited to:

- the possibility that our therapy sessions regarding my treatment could be disrupted or distorted by technical failures;
- In rare cases, the therapist may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video session;

_____ I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

_____ I understand that if there is an emergency during a Telehealth session, then my therapist may call emergency services and/or my emergency contact.

_____ I understand that this Informed Consent is signed in addition to the Notice of Privacy Practices and Permission and/or Consent to Treatment, and that all office policies and procedures apply to Telehealth services.

_____ **AUDIO OR VIDEO RECORDINGS**: I agree not to make audio or video recordings of any portion of sessions.

_____ **CONSENT TO TREATMENT**: I voluntarily agree to receiving mental health assessment, treatment and services, via Face-to-Face or Telehealth, and I understand that I may stop such treatment or services at any time.

By signing this Informed Consent I acknowledge that I have read, understand, and agree to the terms and conditions contained in this Consent. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me.

_____ _____

Signature – Client Date

_____ _____

Marie Denise Guillory, LPC Date