PROFESSIONAL DISCLOSURE STATEMENT & INFORMED CONSENT

Please initial each paragraph below in the available box indicating your understanding and acceptance of terms:

☐ **Qualifications**: Andrea Johnson MEd is a Licensed Professional Counselor in the state of Texas and a National Certified Counselor.

☐ **Emergency/Crisis:** Please know that I do not provide a 24-hour crisis counseling service. Due to the fact that clients are scheduled one after another, it is not always possible to receive a message of an emergency or return a call immediately, but all effort is made to do so in emergency situations. A call back should come as promptly as this counselor's situation will allow. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or contact the crisis hotline at: 1-800-866-2465.

☐ **Counseling Relationship:** During the time that we work together, we will meet weekly for approximately 45-50 minutes per session. Although our session may be very intimate psychologically, we have a professional relationship rather than a social one. Please do not ask me to relate to you in any way other than the professional context of our counseling sessions. You will best be served if our sessions concentrate exclusively on your concerns. To further protect your confidentiality, if I see you in public, I will only acknowledge you if you approach me first.

☐ **Effects of Counseling:** At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

☐ **Client's Rights:** Some clients need only a few counseling sessions to achieve their goals: 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 time though I do request that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you may believe might be harmful. My counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Board of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time, for any reason you are dissatisfied with my services, please let me know so that existing issues can be worked through. If your concerns still persist, you may report your complaints to the Texas Board of Examiners of Licensed Professional Counselors, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5544.

☐ **Referrals:** Should you and/or I believe that a referral is needed, I will provide some alternatives, including programs and/or professionals who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

☐ **Fees:** In return for a fee of **$130.00 per session**, I agree to provide counseling services for you or your child. The fee for each session will be due prior to the commencement of each session. The rate for all subsequent therapy services such as: Interactions with insurance providers, phone calls over 10 minutes, etc. will be billed at $130.00 per hour in 10 minute increments. All returned checks will incur a $30.00 return check fee. As a courtesy, your counselor will

verify, pre-certify, and submit your insurance claim. You understand and agree that you are financially responsible for deductibles, co-insurances and co-payments. You understand that it is your responsibility to familiarize yourself with your insurance benefits and changes that may occur in your eligibility. You understand and agree that failure to do so may result in a denial of your claim and therefore you will be responsible to promptly pay any outstanding balances.

☐ **Cancellations/No Shows:** You are responsible for keeping your appointments. There is a 24 hour cancellation policy. It is your responsibility to notify this counselor at least 24 hours in advance to cancel or reschedule your appointment. In the event that you will not be able to keep an appointment, please give notification 24 hours in advance. If no notice is given, the standard $130.00 fee will be charged to you, regardless of whether you are a self-paying client or a client utilizing insurance benefits. If less than 24 hour notice is provided, a $85.00 late cancellation fee will be charged to you, regardless of whether you are a self-paying client or a client utilizing insurance benefits. After two consecutive missed appointments without notification, your regular time slot will no longer be reserved.

☐ **Records and Confidentiality:** All communications become part of the clinical record. Records are the property of Andrea Johnson LPC. Client records are disposed of five years after the file is closed. Most of our communication is confidential, but limitations and exceptions do exist. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

1. You are a danger to yourself or someone else.

2. There is reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.

3. You direct Mrs. Johnson to release your records.

4. Mrs. Johnson is ordered by a court to disclose information.

Should you request a copy of your counseling records, please be aware that a record preparation fee ($.50/page, minimum of $30.00) will be incurred and a "Release of Records" form must be signed. An overall counseling summary, in lieu of records, will be provided upon request.

In the event that I must telephone you for purposed such as an appointment cancellation or to give/receive other information, efforts will be made to preserve your confidentiality. In regards to email correspondence, electronic communication will be limited to administrative issues (cancellations, rescheduling, etc.) and will not include issues related to your therapy an effort to further preserve your confidentiality. To further protect your confidentiality, if I see you in public, I will only acknowledge you if you approach me first.

In case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress.

In the unfortunate event that Mrs. Johnson becomes unable to continue rendering counseling services to you due to disability or death, by your signature below you are giving permission for another Licensed Professional Counselor, assigned by Mrs. Johnson, to review your file for the purpose of notifying you and possibly transferring you to another appropriate counselor. If this is unacceptable for any reason, notify Mrs. Johnson before signing this document.

Also, in the unfortunate event of your death, what becomes of your confidential records may become an issue. It is possible that several people will want Mrs. Johnson to release information from it or even turn it over to them. It is in your best interest, as well as that of your family, for you to inform Mrs. Johnson in advance to whom you would permit

to release your information, without having a court order. You can choose to not give permission to anyone but if you do want to permit one or more people, please list them on the following lines by fill name and relationship to you.

1._____ Relationship:_____

2._____ Relationship:_____

☐ **Gottman Method**: While I have taken training in the Gottman Method Couples Therapy, I want you to know that I (or my agency, if applicable) am completely independent in providing you with clinical services and I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.

☐ **Court:** I do not agree to serve as an expert witness or to provide testimonial services for you and you agree not to cause me to be used in this way. Should you or your attorney subpoena me as a factual case witness or involve me in court-related proceeding, you agree to pay Mrs. Johnson $300.00 for every hour of my time involved including case preparation, phone calls with attorneys, travel and witness time. If records are subpoenaed, this does not indicate an automatic release of records and I may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest. You further agree to pay a retainer fee of $2,000.00 at the time the subpoena is served, to be applied toward such charges related to court proceedings. If a subpoena is issued for me it will be turned over to my attorney and I will consult with that attorney as necessary. A bill will be rendered to you for immediate payment when a subpoena is issued. Please let me know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motivations.

By your signature below, you are indicating that you have fully read and understood this document, initialed pages 1-3 of this document, are in agreement that any questions you had about this document were answered to your satisfaction, and that you have received a copy of this document. By my signature (Andrea Johnson LPC), I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Client's Signature/Parent (Guardian) Signature: **Date**

Andrea Johnson, M.ED., LPC, NCC **Date**

I hereby state that I have managing conservatorship for (dependent child's name) _____.
I give my permission for him/her to receive counseling services from Andrea Johnson, LPC. I understand that I must provide Andrea Johnson court documentation regarding conservatorship of my child prior to services to be rendered. I understand that Andrea Johnson will not be able to begin counseling services without court documentation.