Lisa Sipes, M.S., M.A., LPC

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Client Information and Consent for Services

Please read the following information carefully and discuss any questions you may have with your therapist

Therapist

The undersigned therapist is a Licensed Professional Counselor. She is engaged in private practice providing mental health services to clients. There is no partnership or corporation associated with anyone with whom she shares office space.

Mental Health Services

Services offered include but are not limited to, children, individuals, and families. The primary clinical orientation of this therapist includes Play Therapy, Cognitive Behavioral and Family Systems therapies. While it may not be easy to seek help from a mental health professional, it is hoped that you will be able to understand your issues and feelings and move toward resolution. It will be important to try new approaches in order for change to occur.

Appointments

Appointments are made by calling 214-734-3477. Please leave a message, and your call will be returned as soon as possible. You must call to cancel or reschedule **at least 24 hours in advance or you will be charged** for the missed appointment. Please understand that a missed appointment without proper notification will be your financial responsibility.

Office Visits

The number of sessions needed depends on many factors and will be discussed by the therapist. Therapy sessions are 50 minutes in length. In order to preserve the professional atmosphere of our office, we must limit the noise and number of people in our waiting area. It is preferable for children to attend only as the "client".

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged the fee for the missed appointment. You are responsible for calling to cancel or reschedule your appointment.

Fees

The initial appointment (intake) is a 75 minute session, and the fee is $95. The charge for a typical individual session (53 minutes) is $85.00, and payment is due at the time of service. Other services such as extended sessions, court appearances and phone calls over 10 minutes constitute additional charges. **Missed sessions without the 24-hour notice will be charged the full fee**. Please talk openly with your therapist if you have a financial hardship. All checks should be made payable to Lisa Sipes. Returned checks will be charged a $20.00 fee.

Insurance

The undersigned therapist contracts with Blue Cross and Blue Shield of TX PPO, and Cigna PPO.

Legal Issues (Court)

Lisa Sipes LPC will not appear in court nor will she take cases that may result in a court appearance. Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality is discussed below. In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records, travel time and time spent in preparing and giving testimony. My fee is $300 per hour for preparation for and attendance at any legal proceedings. The fee for this service begins from the time I leave the office until I return to the office. Also, a $1,500 retainer will be required up front if court appearances occur. This is done regardless of who initiates the proceedings.

Confidentiality

Services are provided on a confidential basis and records are the property of Lisa Sipes, M.A. LPC. 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 board. If you are seen in public, your confidentiality will be protected by acknowledging you only if you approach first. If you have any questions concerning confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated by law, with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health services and payment for those services. You are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

NAME	ADDRESS	PHONE

I consent for the undersigned therapist to communicate with me by email, text, voice message, and by phone at the following addresses and phone numbers and I will IMMEDIATELY advise the therapist in the event of any change:

EMAIL ADDRESS PHONE

Risks of therapy

Therapy is the Greek word for change. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of the efforts on both our parts and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

Emergencies

IF YOU HAVE A LIFE-THREATENING EMERGENCY, YOU SHOULD DIAL 911 OR GO TO THE NEAREST HOSPITAL EMERGENCY ROOM.

Referrals

Should you and/or I believe that a referral is needed, you will be provided the name of an alternate therapist or program to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Therapist's Incapacity or Death

I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my files and records. By signing this information and consent form, I give my consent to allow another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request or to deliver them to a therapist of my choice.

Consent to Treatment

I, voluntarily, agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment or services and that I may stop such care, treatment or services at any time. By signing this Client Information and Consent Form I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been given to me to ask questions and seek clarification of anything unclear to me. In addition, my signature confirms consent to treatment for myself, or if client is a minor child, his or her name is printed below with my signature confirming consent to treatment and certifying that I am the child's parent, guardian, or managing conservator and have the legal right to consent to such services on behalf of the child. I understand that I am responsible for paying all charges incurred.

Ending Counseling

When we as a team decide that your child's goals have been met, and that ending counseling is appropriate, then it is important to titrate the appointments down. I usually prefer to go from once a week, to every other week, then to once a month. Then we will have our final farewell session. Stopping counseling abruptly is not in the child's best interest. We have formed a relationship and

your child will have learned many new skills, therefore it is important to wrap up these skills and our time together in a meaningful way.

My signature below verifies the accuracy of this statement and acknowledges my commitment to the above guidelines.

_____	_____	_____
Client's signature Minor's name	Parent/Guardian/Managing Conservator's signature	Lisa Sipes, M.A., LPC
_____	_____	_____
Date	Date	Date