**Policies, Procedures and Consent to Treatment**

I’m glad to be working with you and your family. I find that providing the following information about the therapeutic process fosters mutual trust and openness necessary for effective work. The following are guidelines for how we can best work together. I welcome any questions and feedback throughout our time together. I view therapy as a collaborative process, where we will work together to establish goals. While specific results cannot be guaranteed from therapy, your satisfaction with the process is of primary importance.

I pledge to provide services in a professional manner consistent with the ethical standards of the Texas State Board of Examiners of Licensed Professional Counselors. You are encouraged to bring any concerns to my attention so that I may work with you to resolve them in a therapeutic manner. If I am unable to resolve your concerns, you may contact the State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

**Appointments:** Appointments are generally scheduled on a weekly basis or at a frequency that is best for you and your situation. Appointments are 55 minutes in length unless otherwise noted. You, as the client, and I, as the therapist, have the right to cancel and/or reschedule appointments as necessary. **Please note that a 24- hour advance notice is required for cancellations or rescheduled appointments, otherwise the full session fee is due.** Once you have completed your final session, or in the event that you have not attended a therapy session in three months, the client/therapist relationship will be considered closed. You many initiate further contact to reestablish the therapeutic relationship at any time.

**Fee Policy:** Payment is due at each session. You may pay by cash, check or debit/credit card. There is a $35 fee for returned checks. At your request, I will provide receipts that you may submit to your insurance company. My standard fee is $125 per 55-minute session. I offer a limited number of reduced fee openings so that those in need may still afford therapy. Please inquire prior to your initial appointment for availability and rates.

**Fees for Services:**

Individuals, Couples or Family Therapy: $125 per 55 minutes, $175 per 90 minutes.

Multifamily Group Therapy: $75 per session.

Adult & Adolescent Group Therapy: $50 per 90 minutes.

Missed appointments (W/O 24-hour notice): **Full Fee**

Review of Records/Written Reports: $100/hour billed in 15 min. increments.

Any legal work (includes consulting, depositions, reports, etc.): $225/hr. billed in 15 min. increments.

Court Appearance (door to door, paid in advance, 4 hr. minimum): $225/hr.

**Please initial below**:

\_\_\_\_\_\_\_ I understand that Teddy Terhune, LPC is acting as my psychotherapist and will not participate in court-related activity, custody disputes, or any other legal services. I understand that if I choose to engage Ms. Terhune in court-related activity that psychotherapy services will be terminated as the therapist-client relationship will have been compromised. I have received clarification as needed.

**Phone Calls & Email**: You are welcome to contact me at any time. I may not be available when you call, but I will return your call as soon as I can, generally within 24 hours during business hours of 10am-5pm Monday through Friday. I am not regularly available for phone calls or email after hours or on weekends. **Do not use text or email for emergencies.** Psychiatric emergencies should be directed to 9-1-1 or your local hospital emergency room.

**Confidentiality:**

The highest standards of confidentiality will be upheld in the therapeutic process. I understand that my therapist respects my right to privacy and that information provided to my therapist will generally be released to others only by my written consent. I understand that my therapist is required by law to disclose confidential information without my consent under certain circumstances that include, but are not limited to, the following:

1. If the client is evaluated to be an imminent danger to himself or others;
2. If any elderly, disabled or minor child is suspected to be a victim of abuse or if I or my child divulge information about such abuse;
3. If a court order or other legal proceeding or statute requires disclosure.

If my sessions are paid by a third party (such as an insurance company) my therapist may be required to provide this third party with documentation of our sessions without my written permission. For out-of-network reimbursement, my therapist will be required to disclose my identifying information and a psychiatric diagnosis. I understand that I am able to ask questions about limits to confidentiality at any time.

**Minor Clients:** Parents have a right to receive feedback on their child’s therapy. However, personal information disclosed by a minor will be kept private unless it pertains to the imminent danger of the child or another person. In order to foster a trusting environment for the minor, the therapist must use discretion when disclosing information to parents. We will discuss this in detail in our initial session. If applicable, I must receive a copy of the current orders regarding custody and/or possession of the child to ensure proper consent, confidentiality and disclosure of information. Exceptions to parental consent may apply to minors 16 years or older who present for treatment regarding sexually transmitted diseases, pregnancy related issues, substance abuse, and/or if the minor is emancipated.

I understand that Teddy Terhune, regularly consults with other professionals to ensure the highest quality therapeutic care. I understand that all legal and ethical confidentiality requirements apply during these consultations.

Your signature indicates that you have received and read the Notice of Privacy Practices available on my website, www.teddyterhune.com, as well as the Policies, Procedures and Consent to Treatment form and agree to abide by the terms therein:

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I do\_\_\_\_\_ do not\_\_\_\_\_\_ wish to receive text ( ) email ( ) confirmation of scheduled appointments.

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Signature (Client or Parent/Guardian) Date