Client Intake & Informed Consent

Tammy Smith, M.Ed., LPC
Licensed Professional Counselor, #74452
4211 I-40 West Suite 101 ♦ Amarillo, TX 79106
806-374-5950 Ext 64♦ FAX: 806.358.4345

GENERAL INFORMATION

My name is Tammy Smith. I have a Master Degree in Education, with a certification in school counseling and I am a Licensed Professional Counselor, #74452 in the State of Texas under the occupations code, chapter 503 which allows me to provide individual, couples, family and group services.

I work with individuals and families from across the life span, dealing with various issues in their lives. Although I am capable of handling a variety of problems, there may situations that I will recommend you to another specialized therapist so you will be better served. Please note that I am not a Psychiatrist, (who is a medically trained doctor), so I am unable to prescribe medication. Also, I am not a Licensed Psychologist and I am unable to administer certain diagnostic tests. I do not provide evaluations for court proceedings. If psychological tests are needed for court proceedings or diagnosis, those will need to be referred to a psychologist.

My approach is an empathetic talk therapy that incorporates multiple therapeutic interventions such as Family Systems, Group, Child/Adolescent/Play Therapy, Art/Music Therapy, Contextual, Cognitive/Behavioral, Solution Focused, Emotion Focused, Restoration Therapy Modalities. My foundation is Christian based and I will seek to incorporate the faith of the clients into therapeutic interventions. However, I will strive to respect client boundaries and personal spiritual beliefs and will in no way impose my beliefs on clients. My goal will be to establish a safe, environment to journey with a client to achieve emotional healing.

APPOINTMENTS

Your first initial visit will be an assessment session which you and I will determine your concerns, and if we both decide that I can provide your therapeutic needs, then we will work on treatment objectives together. Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. Children sessions will be adjusted according to age and ability to focus. Please note all children under the age of 12 must have adult supervision and adults must remain on premises during sessions. Group sessions are approximately 90 minutes long. If you must cancel or reschedule your appointment, please call 806.374.5950 at least 24 hours in advance. Appointments that are not cancelled at least 24 hours in advance will be charged to your account.

Due to the confidentiality policy, excluding minors, we are unable to schedule, confirm, adjust or cancel an appointment from anyone other than the client being seen unless a signed release is on file. If you and your spouse/partner are being seen together for the indicated session, it is acceptable for one party to schedule, confirm, adjust, or cancel an appointment. However, we will not notify the spouse/partner of the appointment change. In the event of a family or medical

emergency a note will be made on the account without disclosing to a third party or family member unless a release is on file.
Please note that my office hours are Monday through Thursday, 8:30-5:30. Services are by appointment only by calling 806-350-5864. You may leave a message and every effort will be made to return any call made during normal business hours within 24 hours. Messages left after hours, or on weekends or holidays will normally be returned the next business day.

PAYMENT
Your first initial session will be an assessment session in which you and I will determine your concerns. If we are both in agreement to policies and my ability to meet your therapeutic needs, we will work on treatment objectives together. The fee for an initial assessment with me as a Licensed Professional Counselor session is $**150.00** There may be other fees assessed for separate profiles or educational materials. The fee for a regular 50-minute session thereafter is $130.00. The fee for a 30-minute session is $65.00. For group therapy, the charge for each 90-minute session is $45.00. These fees are subject to change upon 60 days prior notice to you. **A 24-hour advanced notice for cancellations (non-emergency) is required to avoid a session fee.**

In some cases, treatment will qualify you for insurance payment. If you wish to file with your insurance for therapy costs, I am considered an out of network provider with most insurance companies. Full payment is required until insurance information can be established.

Full payment of fees is expected at the beginning of each appointment. Subsequent sessions will then be scheduled at the conclusion of that session if determined necessary. By signing this agreement you understand that you are fully responsible for all fees.

LITIGATION
In unusual cases you may become involved in litigation that may require my participation. My focus in providing counseling is on treatment and healing. It is NOT my intention to become involved in cases that require evaluation or testimony. When subpoenaed, I may obtain my own legal counsel. If I am required to appear in court or conference via telephone, the client or guardian associated with the subpoena/court request will be required to pay for the preparation time at a rate of **$200.00** per hour. In addition, my fee for participation is **$800.00** for a half day (4 hours) and/or **$1600.00** for a full day. A minimum of **$1000.00** is to be paid 48 hours in advance. Because I must cancel other appointments for this appearance and preparation, this payment will not be refunded for any reason. Additional time required will be billed thereafter.

MINORS
Minors must have parental consent for counseling with the exception that the client is:

- 16 years of age or older and resides apart from the parents/guardians and manages his/her own financial affairs
- Thinking about suicide
- Concerned about alcohol or drug addiction/dependency
- Being sexually, physically, or emotionally abused.

Consenting parents have the right to examine the treatment records of children under the age of 18. In order that minors may have the trust of a protected environment, it is your therapist's practice to

ask the parents to forego that right (progress with the parent/guardian may be discussed) with the exception of extreme circumstances (see confidentiality above).

At the termination of treatment and upon request, your therapist will provide the parent(s)/guardian(s) with a summary of treatment. It is important to note that in the state of Texas children under 17 many not have consensual sex (by law it is considered indecency with a child and therefore child abuse) and the state of Texas requires a therapist to breach confidentiality and report such activity to Child Protective Services (CPS). If your therapist is required to make such a report to CPS about your child, you will be informed as well.

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS

This includes but is not limited to the following: Email, Skype (or any other face time service), chat, mobile devices, cell phones or fax. Please know that our office will maintain your confidentially to the best of our ability; however, we cannot guarantee this with any electronic communication. Please do not send e-mails or texts related to your treatment as electronic communications. **Any therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during your next therapy session**. Any electronic communication by you will be retained in the logs of your service records. While it is unlikely that someone will be looking at these logs, they are in theory, available to be read by the system administrator(s) of the service provider. You should know that any e-mails or texts received from you and any responses sent will become part of your therapy record.

In the event you are contacted or place a call to our staff, please be aware that unless we are both on landline phones, the conversation is not considered confidential and it is possible that your PHI/ePHI could be exposed. Likewise, text messages are not confidential and it is not advised or appropriate to converse about personal issues via text. Face to face sessions are for this purpose. I will make every effort to keep all information confidential. Likewise, it is important that you carefully determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors, and friends. Please only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured.

Be sure to fully exit all online counseling sessions and emails. If you are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, call 806.350-5864 to schedule a new session time.

DUAL RELATIONSHIPS/SOCIAL NETWORKING

Not all dual relationships are unethical or avoidable. Dual relationship situations might impair your therapist's objectivity, clinical judgment, or therapeutic effectiveness, thus will not be encouraged. **If our paths should cross in public, I will not acknowledge you unless you initiate contact. It is preferred that you decide whether or not to disclose your acquaintance (therapist) to others.**

Please be aware that our social networking sites are utilized as a "blog" and not intended to replace personal therapy sessions. In regards to your therapist's personal social networking sites, your therapist may choose not to accept your invitation in the interest in protecting your privacy.

RELEASE OF INFORMATION

If information needs to be released it will only be done according to state law and with a written consent (separate form) from the client indicating an informed consent of such release. In the case of marital therapy, the client is the couple, not individuals; therefore, all records can only be released when both parties consent in writing or if mandated by the court.

INCAPACITY OR DEATH

In the event of the incapacitation or death of myself, it will be necessary to assign your case to another therapist and for that therapist to have possession of your treatment records. By your signature on this form, you are consenting to another LPC/ LPC-Supervisor, LMFT/LMFT-Supervisor, which are personally chosen colleagues preferred by myself, to take possession of your records OR to deliver them to another LPC/LPC-Supervisor, LMFT/LMFT-Supervisor of your choosing.

EMERGENCY SITUATIONS

It is my desire to provide the highest level of care to clients both inside and outside of sessions. For scheduling and non-emergency situations, please contact me at 806.350-5864. In the event you encounter a personal emergency, which will require prompt attention, I will make every effort to accommodate an appointment. If your emergency arises after hours or on the weekend, clients are encouraged to contact a family member, call the Crisis Line at 806-359-6699 or Family Support Services at 806-342-2500, call 911 or go directly to the nearest emergency department.

MODIFICATION AND CONFLICT RESOLUTION

It is agreed that any disputes or modification of agreement shall be negotiated directly between the therapist and client(s). If these negotiations are not satisfactory, then the therapist's client(s) agree to mediate any differences with a mutual acceptable third-party mediator, consisting first of another therapist of the practice. If these negotiations are unsatisfactory, the parties shall move to arbitration and then binding arbitration, choosing an arbitrator mutually agreeable by both. Litigation shall be considered only if and after all of these methods of resolution are given a good faith effort and are unsatisfactory.

RISKS/BENEFITS

It is agreed that the client shall make a good-faith effort at personal growth and engage in the therapeutic process as an important priority at this time in his/her life. Therapy is designed to assist clients in resolving issues and dealing with painful life problems. Your therapist will make every effort to make therapy successful in this manner; however, you should know that therapy is no guarantee that you will solve your problems and that issues will be resolved. Furthermore please be aware, that through the course of therapy, we may expose issues that may cause additional problems to you and bring more life distress. Participation in therapy means that you accept these risks and are willing to deal with the potential problems. Suspension, termination, or referral shall be discussed for lack of commitment or for any unresolved conflict or impasse between counselor and client as soon as possible.

CONFIDENTIALITY

Discussions between a therapist and a client are generally confidential and protected by law. 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
- Negligence suit brought by the client against the therapist
- Filing of a complaint with the licensing or certifying board

If you have any questions regarding confidentiality, you should bring them to my attention so that we can discuss this matter further. I hold confidentiality between clients in the highest regard and will make every effort to protect information shared in our session together. By signing this Information and Consent Form, you are giving consent to Tammy Smith, LPC to share confidential information with all persons mandated by law, with the agency that referred you and are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result. **For Further Information, Review the Notice of Privacy Practices Furnished to you by your therapist at your request with this client information and consent document.**

In Cases of Separation or Divorce:

You agree to provide me with legal documentation regarding conservatorship and your legal rights to consent to treatment for your child. If parents share joint managing conservatorship, both must sign consent to treatment. I will provide treatment that will help facilitate your child's adjustment to the separation or divorce but I do not provide forensic interviews, custody or visitation evaluations, or release of records. I do not serve as an expert witness or provide testimonial services in custody battles. By signing this form, you agree not to subpoena me to court for testimony or for disclosure of treatment records.

_____ _____

Signature of client/parent/consenting adult Date

_____ _____

Therapist Date

DUTY TO WARN/DUTY TO PROTECT

If my therapist 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 my therapist 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 my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

PERSON TO BE CONTACTED	PHONE NUMBER	RELATIONSHIP

_____ _____/_____/_____

Signature of Client or Client's Consenting Adult (if under 18) Date

_____

Relationship of Consenting Adult

_____ _____/_____/_____

Signature of Therapist Date

Please Initial and Sign Below:

_____ I have received a copy of the Informed Consent and Practice Policies from the offices of Tammy R. Smith, M.Ed., LPC

_____I consent to the evaluation and treatment of mental health services, including consultation, evaluation/assessment, treatment planning, and psychotherapy. Although my chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop treatment.

_____ I have read the notice of privacy practices which explains in more detail what my rights are and how my PHI information can be used and shared. I am aware that if my therapist suspects potential child or elder abuse, or has been given reason to believe a client may harm themselves or someone else, the therapist may be legally obligated to breach confidentiality to notify appropriate authorities or individuals.

_____ I understand the risks and limitations to confidentiality with the use of electronic correspondence.

_____I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought and authorize the release of necessary medical information for insurance reimbursement purposes.
_____I have the right to file a complaint if my services fail to conform to the professional code of ethics or licensing laws. To file a complaint with the Texas State Board of Licensed Professional Counselors, I may contact them at:

P.O. Box 141369
Austin, TX 78714-1369
1-800-942-5540

Consent To Treatment: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I agree to participate in therapy with Tammy R. Smith, M.Ed., LPC. I authorize Tammy R. Smith billing services to file insurance on my behalf, if applicable, and assign payments directly to Tammy R. Smith LPC. I understand that if my insurance does not pay for my sessions, I am responsible for the payment of those services.
I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if child is the client), and I understand that I may stop such treatment or services at any time.
NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of the child, or impacting your rights with respect to consent to the child's mental health care and treatment, Tammy R. Smith, M.Ed., LPC will not render services to your child until she has received and reviewed a copy of the most recent applicable court order. You have my permission to call phone numbers _____ regarding my appointments.

_____ _____
Signature-Client/Parent Date

_____
Print-Client/Parent

_____ _____
Therapist Date

HIPPA/HITECH ACKNOWLEDGEMENT OF RECEIPT

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806.350-5862 ♦ FAX: 806.358.4345

Printed Client's Name: _____

Client's Birth Date: ____/____/____

The Office of Tammy Smith, LPC, is required by law to maintain the privacy of and provide individuals with the "Notice of Privacy Practices" with respect to your PHI/ePHI (Protected Health Information/ Electronic Protected Health Information). This notice is located on our website and in paper format with our informed consent. You may also receive a paper copy at no charge upon your request. If you have any objections to this notice, please ask to speak with or leave a message at 806.350-5950 for my HIPAA/ HITECH Certified Office Administrator.

I hereby acknowledge that I received and reviewed the HIPAA/HITECH Notice of Privacy Practice Document.

_____ _____/_____/_____
Signature of Client or Client's Consenting Adult (if under 18) Date

_____
Relationship if Consenting Adult

_____ _____/_____/_____
Signature of Therapist Date

Print-Client/Parent

_____ _____
Therapist Date

INTAKE FORM

Tammy Smith, M.Ed., LPC
Licensed Professional Counselor, #7442
4211 I-40 West Suite 101 ♦ Amarillo, TX 79106
806-350-5864♦ FAX: 806.358.4345

PERSONAL INFORMATION

CLIENT(S) NAME: _____
Last, First, MI

ADDRESS: _____
Street, City, State, Zip

PRIMARY PHONE: (_____) _____

PRIMARY EMAIL: _____

Birthdate: _____ Last grade attended/degree completed: ___

Age: _____ Employer: _____

Race: _____ Length of Employment: _____

Birth State: _____ Occupation: _____

Marital Status: _____ Gross income: _____

SPOUSAL INFORMATION (skip if not relevant to therapy)

Spouse's name: _____ Spouse's Birthdate: _____

Wedding date: _____ Spouse's employer: _____

Either been divorced? _____ Spouse's occupation: _____

If so, who? _____ Spouse's gross income: _____

GENERAL INFORMATION

Names of persons with whom you are now living and their relationship to you (include ages of children):

NAME	AGE	RELATIONSHIP to CLIENT

Emergency Contact: _____

Phone: _____

Address: _____

Relationship to you: _____

State in your words, your reasons for seeking therapy (presenting issue):

When did the present problem start?

Circle how would you describe the severity of your concern in regards to the presenting issue:

MILDLY UPSETTING	MODERATELY SEVERE	VERY SEVERE	EXTREMELY SEVERE	COMPLETELY INCAPACITATING

Have you attended therapy/counseling before? YES or NO

If yes, how many sessions? _____

Circle the type of therapy/counseling you received:

CLINICAL PSYCHOTHERAPY	PASTORAL COUNSELING	ENRICHMENT THERAPY	OTHER

How satisfied where you with the therapy/counseling you received (1 being not satisfied to 5 being satisfied)?

1	2	3	4	5

What else, if anything, have you tried to correct the problem?

In your estimation, circle how interested in counseling you are now:

SOMEWHAT	MODERATELY	VERY INTERESTED

Please give any other information that you feel is important in preparation for counseling:

What do you anticipate achieving? What is/are your goal(s)?

_____ _____/_____/_____

Signature of Client or Client's Consenting Adult (if under 18) Date

_____

Relationship if Consenting Adult

_____ _____/_____/_____

Signature of Therapist Date