Elizabeth Smith, MA, LPC
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COUNSELOR

I am a Licensed Professional Counselor (LPC) and have met the requirements of the State of Texas under the Occupations Code, Chapter 503, which allows me to provide individual, couple's, family and group services. I have a master's degree in my field. My approach is empathetic talk therapy that incorporates multiple therapeutic interventions such as Family Systems, Marital, Contextual, Cognitive/Behavioral, Solution-Focused, Emotion-Focused and Reality Therapy models. My practice is faith-based and I seek, if you desire, to incorporate practices of your faith and spiritual formation such as prayer, bible study, worship, service, small groups, etc., into the therapeutic interventions.

CONFIDENTIALITY

I follow all ethical standards prescribed by State and Federal law. I am required to keep records of your counseling sessions. These records, and the information you share, are carefully guarded. The exceptions to this are outlined in the "Notice of Privacy Practices" which has been provided to you. It is required by law in the State of Texas that I warn and/or protect the appropriate individuals if you intend to take harmful, dangerous, or criminal actions against yourself or someone around you. I must report to the Department of Social Services and/or the Police Department any suicide attempts, incidences of "reasonably suspected child abuse" (physical or sexual), elderly or disabled abuse, abuse of patients in mental health facilities, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases and lawsuits in which the mental health of a party is at issue.

Situations in which I have a duty to disclose information, or when, in my judgment, it is necessary to warn or disclose information include: fee disputes between myself and the client, a negligence suit brought by the client against me, and/or the filing of a complaint with the licensing or certifying board.

I may occasionally find it helpful to consult about your case with other professionals. If so, your identity will be kept confidential, along with your information. **If you should meet me or another member of our staff in public, please know that we will not acknowledge you unless you do so first. I prefer that you decide whether or not to disclose our association with those around you.**

RELEASE OF INFORMATION

If information needs to be released, it will only be done in accordance with State law and with written consent from the client indicating an informed consent to such release. In the case of marital therapy, the "client" is the couple, not each individual. Therefore, records can only be released with written consent from both parties or if mandated by a court of law.

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS

Please know I will maintain your confidentiality to the best of my ability, however, I cannot guarantee this with ***any*** electronic communication. This includes, but is not limited to the following: email, Skype (or any other face-time service), chat, texting, mobile devices, cell phones or faxes.

If you choose to email me, please limit the contents to pragmatic issues such as cancellations and changes in contact information. If you choose to include personal and/or clinical concerns, you may be charged the applicable fee(s) for a normal session. If you wish to use email as a way to "journal" information between sessions, you understand that I may not have the opportunity to review your journal emails until your next scheduled session.

In the event you are contacted by or place a call to our staff, please be aware that the conversation is not considered confidential unless both parties are using land lines, and even then a breach of confidentiality outside of our control may be possible. Likewise, text messages are not confidential, and is it not advised, nor appropriate, to converse about personal issues or concerns via text message.

I will make every effort to keep all information confidential. It is important that you also carefully determine who has access to your computer and electronic information at your location. This includes family members, co-workers, supervisors and friends. If you choose to, please communicate only with a computer or electronic device that is secure whereby confidentiality can be ensured. Be sure to fully exit any online counseling sessions and/or 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 806-374-5950 to schedule a new session time.

DUAL RELATIONSHIPS & SOCIAL NETWORKING

Not all dual relationships are unethical or avoidable. However, dual-relationship situations might impair my objectivity, clinical judgment, and/or therapeutic effectiveness and thus are not encouraged. In regards to my personal social networking sites, I will not accept your invitation to connect or join in the interest of protecting your privacy.

APPOINTMENTS

Subsequent appointments will be scheduled at the end of each session. If you need to cancel an appointment, please call our office at 806-374-5950 to reschedule. If we have your permission, our office may call or email to remind you of an appointment. However, even if no reminder is received, it is your responsibility to attend all scheduled sessions. If you must cancel, please do so at least 24 hours ahead of time. **If you have not notified our office of a cancellation and do not show up for an appointment, you will be charged a fee of $130. This fee is not billable to your insurance company and must be paid out-of-pocket.**

In order to maintain confidentiality, we are unable to schedule, confirm, adjust or cancel and appointment from anyone other than the client being seen (excluding minors) unless we have a signed release on file to do so. 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 appointments. However, we will not notify the other party of any change.

FEES AND PAYMENTS

Initial Evaluation (1st Visit): $150.00
Regular Office Visit (50 Minutes): $130.00
Group Sessions (90 minutes): $50.00

In some cases, treatment may quality for your health insurance company to reimburse me. If you wish to file your health insurance for therapy costs, please contact our Office Administrator, at 806-350-3133 so your benefit level may be established. Your insurance company will require that a mental health diagnosis be placed on your health record at the time we file on your policy. Please feel free to address your concerns or questions with me. **Full payment is required until insurance information is established.**

INCAPACITY OR DEATH

In the event that I die or become incapacitated, it will be necessary to assign your case to another counselor and for him/her to possess your treatment records. Upon your signing this form, you consent that another LPC/LPC-Supervisor, Licensed Marriage and Family Therapist (LMFT), or LPC-Intern within our practice possess your records and/or deliver them to an LPC/LPC-Supervisor, LMFT or LPC-Intern of your choosing.

AVAILABILITY

It is my desire to provide the highest level of care to clients both in and out of sessions. For scheduling and non-emergency situations, please contact me at 806-350-3135. If you have a personal emergency that requires prompt attention, our office will make every effort to schedule an appointment. If it is outside of business hours, you are encouraged to contact a family member or do the following: call the Crisis Line at (806) 359-6699, call Family Support Services at (806) 342-2500, call 911 or go to the nearest emergency department.

MINORS

Minors must have parental consent for counseling with the following exceptions: the client is at least 16 years of age and resides apart from the parents/guardians and manages his/her own financial affairs; the client is considering suicide; the client has concerns about alcohol or drug addiction/dependency; or if the client is being sexually, physically, or emotionally abused. Consenting parents/guardians have the right to examine the treatment records of children under the age of 18. While I am willing to discuss the minor's progress, I may ask parents/guardians to forego the right to examine records except in extreme circumstances (see "Confidentiality" above). This is so minors might have the trust of a protected environment.

At the termination of treatment and upon request, I will provide the parents/guardians with a summary of treatment. It is important to note that in the State of Texas, it is against the law for a child under the age of 17 to engage in consensual sex. I am required by law to breach confidentiality and report such activity to Child Protective Services as this constitutes "indecency with a child" and is therefore considered "child abuse". If I am required to make such a report to CPS about a minor, the parents/guardians will be informed as well.

RISKS AND BENEFITS

It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling 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. I will make every effort to make therapy successful in this manner. However, you should know participation in therapy does not guarantee that you will "solve" your problems or that issues will be resolved. Furthermore, please be aware that through the course of therapy, we may expose issues that cause additional problems with you and bring more life distress. Participation in therapy means that you accept these risks and are willing to deal with the potential problems.

HIPAA/HITECH & NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:
My office is required by law to maintain your privacy. I am required to provide you with a copy of the "Notice of Privacy Practices" outlining my ethical and legal duties in regards to your protected health information in all forms (i.e. all paper and/or electronic data). A copy of this notice is available in paper form and will be provided to you at no cost upon your request. If you have any questions or objections to the Notice, please ask to speak with our HIPAA/HITECH Certified Office Administrator in person or by phone at 806-350-3133.

I HAVE READ THIS AGREEMENT AND I UNDERSTAND THE LIMITATIONS REGARDING CONFIDENTIALITY AND THE RISKS AND BENEFITS OF COUNSELING. I UNDERSTAND MY RESPONSIBILITY TO PAY FOR ALL FEES FOR THE SERVICES I RECEIVE FROM ELIZABETH SMITH, MA, LPC. BASED ON MY UNDERSTANDING OF THIS CONTRACT, I AM GIVING VOLUNTARY CONSENT FOR TREATMENT AND HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES OF ELIZABETH SMITH, MA, LPC.

Client's Printed Name: ____

Client's Signature: ____ Date: ____/____/____

Applicable for Marriage:
Client's Printed Name: ____

Client's Signature: ____ Date: ____/____/____

Applicable for Minors:
Parent/Guardian's Printed Name: ____

Parent/ Guardian's Signature: ___________________________________ Date: ___/___/_____

Counselor's Printed Name: ____

Counselor's Signature: _______________________________________ Date: ____/____/_____

LITIGATION

In unusual cases, you may become involved in litigation that may require my participation. I will need adequate time to prepare for that participation; therefore, an advance notice of 2 weeks is required. This is to ensure my availability and cooperation.
At the time I receive notice of a scheduled court date, the following fees will become due for my professional time.

$800.00 - half day of professional time

$1600.00 - full day of professional time

$200.00 per hour of preparation time

All fees must be paid **prior** to the scheduled court appearance. Please note you will receive an additional invoice for travel and meal expenses.

In the event the court date is cancelled or rescheduled, my office must receive notification **72 hours in advance**. If the required notice is provided, the responsible party will receive a refund of court fees, but no refund will be given for preparation time.

Failure to provide advance notice will result in your account being charged the full day of professional time as well as travel/meal expenses.

By your signature(s) you acknowledge that you have read this notice and agree to the terms.

Client's Printed Name: ____

Client's Signature: ____ Date: ____/____/____

Applicable for Marriage:
Client's Printed Name: ____

Client's Signature: ____ Date: ____/____/____

Applicable for Minors:
Parent/Guardian's Printed Name: ____

Parent/ Guardian's Signature: ____________________________________ Date: ___/___/_____

Office Staff Signature as Witness: ______________________________ Date: ____/____/_____

INTAKE FORMS

May we call or email to confirm appointments? NO YES: Phone / Email / Either

Name: ____ Gender: ________
Last First MI

Address:____
Street City State Zip

Phone: ____
Home Cell Work

Email: ____

Birthday: ___________________ Age: ________ Race: _________ Birth State: ________

Status (circle): Married Separated Single Widowed Divorced / Student Employed Unemployed

Last grade attended/degree completed: _________________

Employer: _______________________________________ Length of employment ____________

Occupation: _______________________________ Gross income: _________________________

Spouse's name: ________________________________ Birthday: _________________________

Length of courtship (*prior to wedding date*): _________ Age when married: You ___________
Spouse _________

Wedding date: _______________ either one been divorced? (Provide dates) ________________

Spouse's employer: ___________________________ Spouse's occupation: ________________

Spouse's gross income: __________________________ Work phone: ______________________

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

____

____

____

Person to contact in emergency: ______________________________ Phone: ________________

Address: _______________________________________ Relationship to you: ________________

Referred by: (circle one) minister, attorney, doctor, another client, relative, friend, other

Name of Referring Party: ____

What issues have brought you here today?

What are your specific goals for counseling?

Previous counseling? No Yes When ________________ by _______________

How helpful was counseling?

Church/Temple you attend _____________________________________

Pastor, Priest, Rabbi____

Average monthly attendance ___________ Pray: Yes No Read Scripture: Yes No

How would you describe your current spiritual life?

Present health (circle one): Excellent Good Fair Poor

Drink cups a day: ______ ______ ______ Type/Quantity a week: ________________
(Coffee) (Tea) (Cola) (Alcohol)

What serious illnesses have you had? When?

What losses have you experienced in the past 2 years? (Death, job loss, move, relationships, etc.)

Family physician: _________________________________

Medications currently taken and their purpose (include non-prescription medications including sleeping pills, diet pills, aspirin, etc.). Please include dosage and schedule.

I hereby acknowledge that the information I have provided on this form is true and accurate.

____ ____/____/____
Client Signature Date