INFORMED CONSENT

Terri Slaughter M.Ed. LPC-S #19832
Licensed Professional Counselor

Please initial next to each section indicating that the information has been read.

GENERAL INFORMATION _____ (initial)

I am an LPC, #19832 (Licensed Professional Counselor) having met the requirements by the State of Texas under the occupations code, chapter 503 that allows me to provide individual, couples, family, and group services as a private therapist. I have a Master's degree in Counseling. My approach is an empathetic talk therapy approach that incorporates multiple therapeutic interventions such as Family Systems, Marital (if married), Contextual, Cognitive/Behavioral, Solution Focused, Emotion Focused and Restoration Therapy Models. Additionally, I will seek to incorporate the faith of the clients along with aspects of spiritual formation such as prayer, bible study, worship, service, small groups, etc. into the therapeutic interventions, if you so desire. I work with individuals, couples, and families from across the lifespan dealing with various issues in their lives. Although I am capable of handling a variety of problems, there may be 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.

APPOINTMENTS _____ (initial)

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. Group/extended sessions are approximately 90 minutes long. If you must cancel or reschedule your appointment, please call 806.350.5863 at least 24 hours in advance. Appointments that are not cancelled at least 24 hours in advance will be charged the full session fee to your account (insurance will not pay this).

Due to our 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 make on the account without disclosing information to a third party or family member unless a release is on file.

FEE SCHEDULE _____ (initial)

Licensed Counseling Sessions for an individual/marriage are $160.00 initial session and $140.00, thereafter. Group Sessions will be $60.00 per person. 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. If you wish to file your health insurance for therapy costs, please contact my Office Administrator at 806-350-3133 so the benefit level may be established. Your insurance company will require a mental health diagnosis be placed on your health record at the time we file on your policy. Full payment is required until insurance information is established. By signing this agreement, you understand that you are fully responsible all fees.

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS _____ (initial)

This includes but is not limited to the following: Email, Skype (or any other face time service), chat, texting, mobile devices, cell phones or fax. Please know that our office will maintain your confidentiality to the best

our ability: however, we cannot guarantee this with any electronic communication. If you choose to email me from your personal email account, please limit the contents to pragmatic and/or clinical concerns. Please know you may be charged applicable fees for a session.

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 is 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. By signing this agreement, you understand that if you communicate through your tablet or phone you release the therapist from any breach of confidentiality when signing this document. 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 806.350.5863 to schedule a new session time.

LITIGATION _____ (initial)

In unusual cases you may become involved in litigation that may require my participation. You will be expected to pay for the professional time of $800.00 for ½ day (4 hours) and/or $1,600.00 for a full day (8 hours). All fees are to be paid prior to the scheduled court appearance. In addition, there will be an invoice for travel and meal expenses, if incurred. In the event the court date is cancelled or rescheduled our office must receive notification 72 hours in advance. Please call 806-350-5863. If the required notice is provided, the responsible party will receive a full refund of paid professional 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 you have read this notice and agree to the terms and fully responsible for all fees.

RELEASE OF INFORMATION _____(initial)

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 ____ (initial)

In the event of my 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.

DUAL RELATIONSHIPS & SOCIAL NETWORKING _____ (initial)

Not all dual relationships are unethical or avoidable. However, dual relationship situations might impair my 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.

EMERGENCY SITUATIONS ____ (initial)

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 806.350.5863. In the event you encounter a personal emergency which will require prompt attention, my office will make every effort to accommodate and appointment. If your emergency arises after hours or on the weekend, clients are encouraged to contact a family member call 911 or go directly to the nearest emergency department.

RISKS & BENEIFTS _____ (initial)

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. 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 therapist and client as soon as possible.

MODIFICATION AND CONFLICT RESOLUTION _____ (initial)

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 these methods of resolution are given a good faith effort and are unsatisfactory.

MINORS _____ (initial)

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; is thinking about suicide; concerned about alcohol or drug addiction/dependency; or 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 my practice to ask 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, I 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 may not have consensual sex (by law it is considered indecency with a child and therefore "child abuse'') and the state requires me to breach confidentiality and report such activity to Child Protective Services. If I am required to make such a report to CPS about your child, you will be informed as well.

CONFIDENTIALITY ____ (INITIAL)

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: report 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; suits in which the mental health of a party is an issue; situations where I have a duty to disclose, or where in my judgment, it is necessary to warn or disclose; fee disputes between myself and the client; negligence suit brought by the client against the therapist; and, filing of a complaint with the licensing or certifying board.

Complaints Management and Investigative Section
PO Box 141369
Austin, Texas 78714-1369

I may occasionally find it helpful to consult about a case with other professionals and if this should arise, your identity will not be revealed. In addition to your confidentiality being important to me, and I am ethically bound to keep the information confidential. If you should meet a member of our staff and/or therapist in public, please know they will not acknowledge you unless you initiate contact. It is preferred that you decide whether to disclose your acquaintance to others. 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 Terri Slaughter, 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.

DUTY TO WARN/DUTY TO PROTECT _____ (initial)

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

By signing below you acknowledge you have read this notice and agree to the terms.

Client Printed Name: _____

Client Signature: _____ Date: ___ / ___ / ___

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name (Spouse): _____

Client Signature (Spouse): _____ Date: ___ / ___ / ___

APPLICABLE for MINOR

Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Signature of Therapist: _____ Date: ___ / ___/ ___

HIPPA / HITECH

ACKNOWLEDGEMENT OF RECEIPT

Printed Client's Name: _____

Client's Birth Date: ____/____/____

The Office of Terri Slaughter MEd, LPC-S, 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 806.350.3133 for my HIPAA/ HITECH Certified Office Administrator.

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

By signing below you acknowledge you have read this notice and agree to the terms. Client

Printed Name: _____

Client Signature: _____ Date: ___ / ___ / ___

APPLICABLE for MARRIAGE/COUPLE

Client Printed Name (Spouse): _____

Client Signature (Spouse): _____ Date: ___ / ___ / ___

APPLICABLE for MINOR

Client Printed Name: _____

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Therapist Name: Terri Slaughter LPC-S

Signature of Therapist: _____ Date: ___ / ___ / ___

INTAKE FORM

Terri Slaughter M.Ed. LPS-C #19832

INFORMATION

Client Full Name: _____ Gender: M / F

Legal Guardian (if client is a minor): _____

Primary Address: _____
Street City State Zip

Primary Phone: _____ _____
Cell Email Address

Birthdate: _____ Age: _____ Race/Ethnicity: _____

Relationship Status: _____ Year/Degree of school: _____

Employer: _____ Length of Employment: _____

Occupation: _____ Gross Income: _____

Spouse's name (if applicable): _____ Birthdate: _____

Spouse's employer: _____ Spouse's Occupation: _____

Wedding Date: _____ Length of Time Dated/Engaged: _____

Either been divorced?: _____ If so, provide dates: _____

Children with previous spouse?: _____

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

Name	Age	Relationship to Client

Emergency Contact: _____ Phone: _____

Address: _____ Relationship to client: _____

Referred to Terri Slaugther LPC-S by: _____

State the reasons for seeking therapy and when the problem began (presenting issue):

Circle the severity of the concern in regards to the presenting issue:

MILDLY UNSETTING	MODERATELY SEVERE	VERY SEVERE	EXTREMELY SEVERE	COMPLETELY INCAPACITATING

Previous Counseling/Therapy before? Yes or No

If yes, how many sessions? _____ When? _____

With Whom? _____

How satisified was the therapy/counseling your received (1 being not satisfied to 5 being satisfied)?

1	2	3	4	5

Describe your relationship with your father (or father's relationship with adolescent, if parent).

Describe your relationship with your mother (or mother's relationship with adolescent, if parent).

Present physical health:

Excellent	Good	Fair	Poor

What is the anticipated out comeof therapy? What is/are your goal(s)?

Are you currently taking medication? Yes or No
If yes, please list names, dosages prescribing doctor for each.

Client Signature: _____ Date: _____ / ____ / _____

CREDIT CARD AUTHORIZATION FORM

EFFECTIVE DATE: _____/_____/_____

I, _____ authorize the office of **Terri Slaughter, LPC-S** to place a charge on my credit/debit card for the purpose of Therapy.

The agreed amount of $140.00 will be charged per session.

In the event of a NO SHOW or LATE CANCELLATION, a session fee of the ***AGREED AMOUNT*** will be charged to my card.

CC: ____ ____ ____ ____ ____ ____ ____ ___ ___ ____ ____ ____ ____ ____ ____ ____

EXP DATE: ____ / ____ CVV: ____ ____ ____ ____ (3 or 4 digits) ZIP: ____ ____ ____ ____ ____

_____ ____/____/____
Card Holder's Signature Date

_____ ____/____/____
Therapist or Office Staff Date

Please call our office at 806-350-3133 between the hours of 8AM-3PM Monday through Friday if there are any questions of concerns regarding your account.

Health Declaration

Terri Slaughter MEd, LPC-S is committed to providing the highest level of care for you. Considering the ever-evolving restrictions and requirements due to the COVID-19 outbreak, I must take additional steps to ensure your well-being, in addition to each AFI client and team member. Out of an abundance of caution, I am requiring all clients to make the following disclosures.

Your ***initials*** below indicate your agreement with these statements.

_____ Neither I nor any family member have experienced flu-like symptoms in the past 3 weeks. The CDC defines such symptoms as fever or 100.4 or higher, a cough, shortness of breath, loss of taste or smell.

_____ In the event that either I or family member have flu-like symptoms, I will notify the therapist to reschedule the appointment.

_____ I understand that according to the CDC, people over the age of 65 and/or people of all ages with an underlying medical condition are at higher risk should they contract COVID-19. If I self-identify as a member of the higher risk group, I understand and agree that I am aware of the risks of attending my therapy session, and my initials indicate that I accept those risks.

_____ I hold Terri Slaughter MEd, LPC-S free, safe and harmless from any and all damages, liabilities, costs, losses, or expenses, including reasonable attorneys' fees and court costs arising out of or in connection with my attending therapy sessions, and any claim, demand, or action by a third party against Terri Slaughter and Amarillo Family Institute in any way related to attending therapy sessions.

I regret the need to introduce this type of worry into your experience and look forward to serving you. If there is anything I can do to make your experience more comfortable please let me know.

I, (print name)_____ have read the preceding information and understand the conditions as read and give my consent for therapy under these conditions.

_____ _____

Signature of Client Date