Client Informed Consent

Melinda Zalman, M.A., LPC Associate
Supervised by Terri Clements Slaughter, M.Ed., LPC-S

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

GENERAL INFORMATION _____ (initial)
I am an LPC-Associate, #83183 (Licensed Professional Counselor Associate) supervised by Terri Clements Slaughter, MEd, LPC-S* (Licensed Professional Counselor Supervisor) 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 under supervision. I have a graduated with my Master's of Art in Professional Counseling from Dallas Baptist University. I am a Level 1 Restoration Therapist 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 45-50 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 806-300-8338 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.
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 $75 a session. Group Sessions will be $35.00 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. I cannot accept insurance at this time. Payments can be made in cash, check, or Square credit/debit card payments. Please make checks payable to Amarillo Family Institute. By signing this agreement, you understand that you are fully responsible for 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 806-300-8338 to schedule a new session time.

CONTACT OUTSIDE OF SESSIONS _____ (initials)
You may contact me outside of session times via email, call, or text. I will not respond to email or texts or answer calls on the weekends or after work hours. Please limit contact outside of session to scheduling issues. Please know that any phone call that lasts for more than **15 minutes** will cost you the price of a full session (**$75**).
Email: melzalmancounseling@gmail.com
Phone: (806) 300-8338 (accepts calls and texts)

LITIGATION _____ (initial)
In unusual cases you may become involved in litigation that may require my participation. At this time, all litigation requiring my participation will also require the participation of my supervisor. You will be expected to pay for the professional time of $300.00 (Melinda) + $800.00 (Terri) = $1100.00 for 1⁄2 day (4 hours) and/or $600.00 (Melinda) + $1,600.00 (Terri) = $2200.00 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 806-300-8338. 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.

CLIENT RECORDS _____ (initial)
All our communications become part of the clinical record, including electronic communication. Adult client records are disposed of seven years after the file is closed. Guardians or conservators do have access to child-client files and will need to sign for consent of services (within joint custody cases, only one guardian or conservator is needed to sign for consent for the child). Minor client records are disposed of seven years after the client's 18th birthday. Should you request a copy of your counseling records, please be aware that a $30.00 record preparation fee will be incurred for files under 50 pages and a $50.00 record preparation fee will be incurred for files 50-100 pages. Additionally, a **"Release of Records"** form must be signed. An overall counseling summary, in lieu of records, will be provided free of charge upon request.

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.

I**NCAPACITY 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. Please be aware that your counselor will not accept friend/follow requests from you in the interest of protecting your privacy as well as maintain professional boundaries.

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 806-300-8338. 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 & BENEFITS _____ (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. If the parents of the child receiving counseling are separated, divorced, or were never married, I need a copy of the Divorce Decree, Custody Decree, or other Court Orders affecting the rights of parents, guardians or others. I will need a copy of these papers **before** I can meet with your child. If I do not have the appropriate court orders, I will not be able to meet with your child for counseling.

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 Melinda Zalman, MA, LPC-Associate supervised by Terri Clements Slaughter, MEd, LPC-S* 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_____

ASSOCIATE SUPERVISION AND RECORDED SESSIONS _____ (initial)
As an LPC-Associate, I am supervised by Terri Clements Slaughter, M.Ed., LPC-S*. I meet with my supervisor on a weekly basis as I continue to learn and grow as a counselor. I may discuss some aspects of your counseling process with my supervisor to learn how to help you better. During my supervision, I

may ask to videotape your session to help the learning process. You have the option to decline videotaping of your sessions. Declining to videotaping will have no affect on your therapy and/or my ability to see you. If you have any issues or concerns about my abilities as a counselor, please contact Terri Slaughter*.

*__**Terri Clements Slaughter, M.Ed., LPC-S**__
License Number 19832
Amarillo Family Institute
4211 I-40 West Suite 101
Amarillo, TX 79106
Phone: (806) 350-5863
Fax: (806) 358-4345

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

Client Printed Name: _____

Signature (Client) Date

Signature (Parent/Legal Guardian #1) Date

Signature (Parent/Legal Guardian #2) Date

I _____ (printed name)

___ consent to the videotaping of my sessions.

___ do NOT consent to the videotaping of my sessions

Signature Date

Terri Clements Slaughter, MEd, LPC-S
Melinda Zalman, M.A., LPC Associate

LPC-Associate Counseling Agreement

Please initial the following statements to acknowledge your understanding:

_____ I understand that I am seeing a counseling associate for counseling services. This associate is earning hours toward counseling licensure.

_____ I understand the limits of confidentiality as explained by my counselor and I have had the opportunity to ask questions about these limits.

_____ I understand that I may, at any time, request to see associate supervisor, Terri Clements Slaughter, MEd, LPC-S for counseling services.

_____ I understand that the dynamics of my case will be discussed for staffing and educational requirements with the counseling associate and supervisor.

_____ I understand that some sessions may be directly observed by the LPC Supervisor.

_____ I understand that some sessions may be videotaped for supervision and educational purposes.

_____ I understand the supervisory relationship and the requirement for supervision do not otherwise affect my rights to confidentiality, which will be maintained within the limits of the law.

_____ I understand that I am not required to sign this document.

_____ _____

Client's Printed Name Date

_____

Signature of client OR parent of legal guardian, if client is under 18 years of age

4211 I-40 West Suite 101, Amarillo TX 79109
806-350-5863

HIPPA / HITECH ACKNOWLEDGEMENT OF RECEIPT

Printed Client's Name: _____

Client's Birth Date: ____/____/____

The Office of Melinda Zalman, MA, LPC-Associate supervised by Terri Clements 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: Melinda Zalman LPC-Associate

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

Client Intake

Melinda Zalman, M.A., LPC Associate
Supervised by Terri Clements Slaughter, M.Ed., LPC-S

Client Full Name:_____

Legal Guardian/Parent #1 (if client is a minor):_____

Legal Guardian/Parent #2 (if client is a minor):_____

Primary Address:_____
Street Address City State Zip

Primary Phone:_____

Cell Phone:_____

Permission to leave a message? YES NO

Email Address:_____

Permission to email and/or text? YES NO

Birthdate:_____

Relationship Status:_____ Employer/School:_____

Occupation/Grade/Major:_____

Spouse's name (if applicable):_____

Wedding Date:_____ Either been divorced?:_____

Children with previous spouse?:_____

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

Name	Relation to Client	Age

Emergency Contact: _____

Phone: _____

Address: _____

Relationship to the client: _____

PARTY RESPONSIBLE FOR PAYMENT (If different from Client)
This does not give them permission to notes, unless client is a minor and responsible party are legal guardians/parents. You may be asked to sign a release of information form so that your counselor may discuss fees and payments with this party.

Name _____ Date of Birth _____

Address _____
Street Address City State Zip

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 NO

If yes, how many sessions?_____ When?_____

With Whom?_____

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

1	2	3	4	5

Present physical health:_____

What is the anticipated out come of therapy?_____

What is/are your goal(s)?_____

Are you currently taking medication? YES NO If yes, please list names, dosages prescribing doctor for each.

_____

_____

Credit Card Authorization Form

Melinda Zalman, M.A., LPC Associate
Supervised by Terri Clements Slaughter, M.Ed., LPC-S

EFFECTIVE DATE: _____/_____/_____

I, _____ authorize the office of Melinda Zalman, LPC-Associate to place a charge on my credit/debit card for the purpose of Therapy.

The agreed amount of $75.00 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.