Client Informed Consent

Melinda Zalman, M.A., LPC

Hello and welcome to my office, I am glad you are here. I am committed to providing you with quality care. Therapy is a relationship between people that works, in part, because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change. As a client of psychotherapy, or counseling, you have certain rights that are important for you to know. Your rights include:

- The right to know the level of training, credentials, and theoretical orientation of your counselor.
- You have the right to review copies of the records the counselor keeps on your behalf. However,
- if you do make a request to see your file, the counselor is free to tell you if he thinks it would be
- harmful to you or otherwise not in your best interest to see it.
- You have the right to know that the process of counseling could open up levels of awareness or lead to changes that could produce pain, anxiety, or turmoil in your life or relationships.
- You have the right to decide not to receive counseling from your present counselor and/or end counseling at any time without additional obligation. If you wish, the counselor will provide you with a referral to another qualified counselor.

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

YOUR COUNSELOR _____ (initial)
I am an LPC, #83183 (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. 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. Please note that I am not a Psychiatrist (who is a medically trained doctor) and, therefore, am unable to prescribe medication. I am not a Licensed Psychologist and am unable to administer certain diagnostic tests. I am a member of the American Associate of Christian Counselors and the Texas Counseling Association.

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 made 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 $130 a session. Group Sessions will be $50.00 per person. Sessions longer than 50 minutes must be agreed upon beforehand and will cost an additional $65/30 minutes. 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, Venmo, or Square credit/debit card payments. Please make checks payable to Melinda Zalman. By signing this agreement, you understand that you are fully responsible for all fees.

CONFIDENTIALITY _____ (initial)
This is your therapy; the goal of which is your growth and wellbeing. There are certain legal limitations to those rights that you should be aware of. As a therapist I have corresponding responsibilities to you. Trust and openness are essential for effective therapy. Confidentiality is carefully protected. 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:

- Suspected child abuse or neglect must be reported to the Texas Department of Family and Protective Services by law.
- Abuse, neglect or exploitation of the elderly or disabled must be reported to the Texas Department of Family and Protective Services by law.
- Abuse of patients in mental health facilities must be reported to the State of Texas by law.
- Sexual activity of a minor (under 17-years-old) will be disclosed to the parent(s)/legal guardian(s) of the Client in order to protect the Client.
- Sexual exploitation must be reported to the State of Texas by law.
- If your records are subpoenaed or if a judge issues a court order requiring the disclosure of your records, I am legally obligated to comply.
- If you authorize me to release your records to another person or party, I will comply with your authorization.
- If you file a lawsuit against me for any reason, or if you file a complaint against me with my licensing board, I may use your records and confidential information to defend myself.
- If a court order or other legal proceeding (such as a grand jury) requires the disclosure of your records or confidential information, I will obey the court order or the grand jury subpoena.
- If I learn of previous sexual exploitation by another mental health provider, I am required to report it to the District Attorney in the county where the alleged exploitation occurred and to the licensing board of the other professional within three (3) business days.
- Matters discussed during a family therapy session or a couple's therapy session are not confidential as to the persons present since those persons hear the statements made and participate in the discussion. However, all matters discussed during family or couple's sessions are confidential and privileged as to third parties who were not present in the session.
- I require a "no secrets" approach to counseling multiple individuals. Members of a family or a couple should not disclose information to me in a private session or outside of session that they do not want me to share with the other family members or partner. I am not the gatekeeper of your private information – you are. I will not be responsible for keeping track of what information can or cannot be shared with other participants in the family or couple therapy. If you must discuss personal information that cannot be shared, you should seek individual counseling with your own therapist.

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 sessions together. By signing this Informed Consent Form, you are giving consent to Melinda Zalman, 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.

ELECTRONIC COMMUNICATION _____ (initial)
I currently offer a range of Telehealth psychotherapy services via phone and secure videoconferencing within the State of Texas. The security of e-mail and text messaging cannot be guaranteed and as such are not appropriate for discussing clinical matters. If you need to discuss a clinical matter between sessions, please call me. I do not allow clients to record sessions unless we have agreed to this in advance and you have signed a specific written authorization for the taping to occur. By your signature below, you acknowledge that you understand my policy on recording sessions and you agree to abide by it. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not engage in communication or relationships via social media with clients. This is to protect your privacy as well as the therapy relationship. I do not accept "friend" requests from current or former clients on any social networking site due as this can compromise clients' confidentiality and privacy. An attempt to "add" or "follow" me on any form of social media will result in you being blocked.

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 (**$130**).

LITIGATION _____ (initial)
Please note that I am not trained as a forensic specialist or expert witness. If you are seeking these services, I would be happy to provide you with a referral. The rights to privacy and confidentiality are paramount to the counseling relationship. I work hard to prioritize and protect these rights. Please note that testimony in court and other legal proceedings may compromise these rights. As such, I do not voluntarily testify in court cases. If required to testify I cannot guarantee my testimony will be favorable to you and am not responsible for any outcome, or judgments made, regarding any court case and you agree to not hold me responsible in any way for such. If I am compelled to testify in court as a factual witness my court appearance and/or testimony fee is a flat rate of $2,000 per day REGARDLESS OF WHICH PARTY ISSUED THE SUBPOENA OR REQUIRES ME TO TESTIFY. These fees cover the time required for preparation, travel time (door-to door), mileage outside Potter or Randall Counties, waiting time spent logged in for any remote hearing, and attendance at the legal proceeding, including waiting time and time spent on the stand or in deposition. The minimum nonrefundable fee of $2,000 must be paid 5 business days in advance. This is required as I will have to clear my calendar of appointments so that I may be available to appear in court. NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES. In the event I receive a summons to testify less than 5 days prior to the court date, all fees due to myself and my clinical supervisor will be doubled, and I reserve the right to take legal action to contest the subpoena. No further appointments will be scheduled until all court-related fees are paid in full. Please be advised, if I receive a subpoena to testify in a divorce and/or custody case, I will not make any custody recommendations, a recommendation on where the child should live, nor will give an opinion on parental fitness. By your signature below, you indicate your understanding of, acceptance, and agreement with this litigation policy and fee structure.

CLIENT RECORDS _____ (initial)
All of 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.

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.

EMERGENCY SITUATIONS AND CRISES _____ (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. Please note that I am not a 24-hour crisis line. In the event you encounter a personal emergency which will require prompt attention, my office will make every effort to accommodate an appointment. If you are able to meet with another therapist, you will be responsible for paying their fee, fees vary based on credentialing and experience. If an emergency arises please 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.

DIVORCE/SEPARATED PARENTS OF A MINOR _____ (initial)
If a divorce or a separation of parents involving the children of the marriage has occurred or occurs during treatment, a current copy of any relevant court documents is required to begin or continue services. If joint custody exists, the parent not bringing the child will also be contacted via letter with then binding arbitration, choosing an arbitrator mutually agreeable by both. Litigation shall be considered an intake form and an invitation to that parent to call with any questions and to participate in their child's counseling. My policy is to involve both parents whenever possible. I require a payment plan to be agreed upon by divorced or separated parents, prior to the commencement of counseling services, to provide specific terms of payment for the individual counseling sessions, and the session charges for children of the relationship, irrespective of the age of the children. This agreement will be signed by each member of the family or each party mentioned within the agreement.
I do not provide forensic interviews, custody or visitation evaluations, or release of records for this purpose. I do not serve as an expert witness or provide testimonial services in custody suits. By signing this form, you agree not to subpoena me to court for testimony or for disclosure of treatment records regarding custody or parent fitness.

COMPLAINTS _____ (initial)
You have the right to have your complaints heard and resolved in a timely manner. If we cannot work things out to your satisfaction, you may file a complaint with my licensing board, the Texas Behavioral Health Executive Council, 1801 Congress Avenue, Suite 7.300, Austin, TX 78701, Telephone: 1-800-821 3205, or online: http://www.bhec.texas.gov/wp-content/uploads/2020/07/BHEC-Complaint-Form.pdf. If you have a compliant concerning the HIPAA Privacy or Hitech regulations, you may contact the U.S. Department of Health and Human Services, Office for Civil Rights, at: OCRMail@hhs.gov.

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_____

TERMINATION OF COUNSELING _____ (initial)
Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though it is requested that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. I assure you that my counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Boards of Examiners of Licensed Professional Counselors and Marriage and Family Therapists and the HIPAA security and privacy rules. If at any time or for any reason you are dissatisfied with my services, please let me know so that existing issues can be worked through. Should you miss two appointments concurrently, our counseling relationship can

terminate, and you will be provided with a referral list upon request to another facility, should you want to continue counseling services. You will be responsible for contacting and evaluating those referrals and/or alternatives. If you continue to not show for your appointments, (even with a 24-hour notice), you will also be referred. If you intend to discontinue counseling, please inform me as soon as possible so that other clients can be served.

HIPAA/HITECH AND NOTICE OF PRIVACY ACKNOWLEDGMENT 7 _____ (initial)
Our office is required by law to maintain the privacy of and provide individuals with a copy of or "Notice to Privacy Practices" of our ethical and legal duties in regard to your protected health information in all forms (i.e. all paper and/or electronic data). A copy of this notice is on our website and is available in paper form. A copy 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.

INFORMED CONSENT
I give my informed consent for Melinda Zalman, LPC to provide counseling services and psychotherapy to myself and/or my child as set forth below. I have read (or had read to me) this Agreement, I understand the terms of this Agreement, and I agree to comply with them. I understand that this Agreement is a contract between me Melinda Zalman, LPC and may be legally enforced as a written contract. I agree that this Agreement will stay in effect until I revoke it in writing. I understand that any revocation of this Agreement must be dated after the date of this Agreement and a must be provided to Mrs. Zalman. I further agree that a copy of this Agreement has the same force and effect as the original.

_____
Printed Name (Client)

_____
Signature (Client) Date

_____
Printed Name (Parent/Legal Guardian #1)

_____
Signature (Parent/Legal Guardian #1) Date

_____
Printed Name (Parent/Legal Guardian #2)

_____
Signature (Parent/Legal Guardian #2) Date

Credit Card Authorization Form

Melinda Zalman, M.A., LPC

EFFECTIVE DATE: _____/_____/_____

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

The agreed amount of $130.00 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

The fee for a returned check or declined credit card charge is $35. Not confirming an appointment does not constitute canceling the appointment. If you are unable to make a scheduled appointment, please contact me as soon as possible. Missed appointments which are not canceled or rescheduled at least 24 hours before your appointment will be charged the full amount. Two consecutive missed appointments without contacting me will result in being taken off the schedule. If you are late for your appointment, we will end on time and not run over. Payment for appointments can be made via cash, check, charge, or Venmo. Regardless of how you intend to pay, please complete the credit card authorization. This card will only be charged per your request for your counseling sessions or in the event an appointment is missed without appropriate cancellation or notice. Unless other arrangements are made this card will be used for all counseling fees and any charges associated with missed appointments.

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

Client Intake

Melinda Zalman, M.A., LPC

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

If you would like to receive appointment reminders via text or email, please draw a star next to the phone number(s)/email(s) you would like the reminders to be sent to.

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.

_____

_____