8951 Collin McKinney Pkwy #904
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Phone: 469-401-8033 Fax: 469-301-1308
info@mindfulreflectionscounseling.com

INFORMED CONSENT

SOME THINGS YOU SHOULD KNOW ABOUT COUNSELING

Before we start counseling together there are some things that you should know about the counseling process and about our office. In legal terms, this is called "Informed Consent." This information will help you understand better what to expect, and it will explain some limitations about what you and your clinician will be doing.

Your Privacy and Confidentiality

Of course, all of our work together – our conversations, your records, and any information that you give us – is protected by something called legal *privilege*. That means that in most cases the law protects you from having information about you given to anyone without your knowledge and permission. Our office respects your privacy, and we intend to honor your *privilege*. However, the law also makes some important exceptions to your privacy.

If we believe there is a risk you might harm yourself or someone else, we may be required to contact the authorities to give them the opportunity to protect you. If you are abusing children, an elderly person, or a disabled adult, we must notify the authorities, so they can protect others from harm. Also, if you become involved in any lawsuit in which your mental health is an issue – for example, a custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering – then the court or the lawyers may insist upon, and may obtain your information from us. Similarly, you would lose the protection of your privilege if you file a complaint against us with the state licensing board or if you sue us.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third-party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. By your signature, below, you authorize our office to provide information to your insurance and managed care companies to the extent necessary for them to pay for your services. If we find ourselves in a dispute with you over billing, our office may provide a collection service any information necessary to clarify and to collect an outstanding balance.

Side effects of counseling and other potential unpleasantness

You should know that counseling is not always easy. You may find yourself having to discuss personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate those problems, but sometimes at first, as you get to the root of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel uncomfortable or awkward. Sometimes counseling requires trying new and unfamiliar ways of doing things. You will always be free to move at your own pace, however. We will work with you to make changes, but we cannot promise anything about the results you will obtain. The outcome you achieve will depend on many things.

Our office specializes in individual/couples/family psychotherapy and psychological assessments. If we believe that your problem requires knowledge that we do not have, we may refer

you for a consultation with someone with specific training or experience. We will discuss any such referral with you before we act. At the very beginning we will create a treatment plan with you. That is, we will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and how long it will take. Every now and again, we will review that plan to see if it needs to be updated.

Our office policies

Therapy sessions usually last 45 to 60 minutes, and we must end each session promptly. Payment is due at the time of your appointment. We can accept cash, checks, or credit cards for your payment. Our office will charge a $80 fee if you are late, or if you cannot make your appointment and you do not cancel the appointment at least twenty-four hours in advance. Your insurance will not pay for missed sessions; you must pay for those, yourself. Our office charges a $30 fee for any check returned for any reason.

Our telephone is only answered during business hours. Through the day, we check messages regularly, and whenever possible we try to return phone calls the same day; however, phone calls after 3 p.m. will be returned by the next business day. If we have not returned your call within twenty-four hours, please try again as your message may have been lost. If you have an emergency after that time, call 911, or go to an emergency room and ask them to contact us.

When we are out of the office for several days, the messages you leave may be answered by another clinician. We will probably not have discussed your case with that person, but he or she will make every effort to be helpful to you in our absence.

Your clinician will meet with you on a regular basis, usually every week or two weeks. You will be charged for any appointments that you miss if you do not call our office at least 24 hours in advance of the appointment. If you miss a scheduled visit, it is your responsibility to call the office to schedule another appointment if you wish to continue your counseling effort. After a missed appointment, if you do not call our office within ten days to reschedule, your clinician will accept that as your notice that you have terminated counseling with our office and that you wish to have no further services from our office.

After hours telephone calls may be accepted. There is no charge for a phone call that lasts ten minutes or less. For telephone consultations that require more than ten minutes, our office charges $30.00 for each fifteen-minute increment or any part of a fifteen-minute increment. Both of these fees are due and payable when they are incurred, but must be paid by the time of your next scheduled visit; insurance does not ordinarily pay for telephone consultations. There may be times when you want your clinician to read documents that will help with understanding you and your needs. If reading such documents requires more than fifteen minutes, your clinician will bill you for that time, fees that your insurance company, generally, will not pay.

Other charges may apply: If you, or someone else (for example, another clinician or your lawyer), needs a copy of your file or of other records that may be legally necessary, our office charges a reasonable fee for copying, plus postage. If our office is required to provide a verbal report, for example by telephone to your physician, a ten-minute consultation will not be charged. If the consultation exceeds ten minutes, our office charges $120 per hour; that fee is billed in fifteen-minute increments for each quarter hour or part of a quarter hour. If our office must produce a written report, the same fee will be billed for the time spent reviewing your file and drafting and publishing the report.

mindful reflections
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Other Office Policies

Our clinicians are not allowed to accept gifts from patients. While we appreciate your thoughtfulness, we are prohibited by the canons of our profession from accepting gifts from our patients.

Similarly, our professional practice standards prohibit our clinicians from accepting requests to connect or to be "Friends" on internet sites such as Face Book, LinkedIn, Twitter, and other electronic and social media.

By your signature below you authorize our office to designate an appropriate professional to serve as custodian of your record, and who will assume possession of, and responsibility for your treatment record in the event of your clinician 's death or disability. In that event notice will be posted, as necessary, on your clinician 's web page and telephone voice mail.

Your Treatment

Type of Treatment requested and planned: ______________________________________

Your clinician 's customary Fee is: $150 per session

Your Copay (if you are using a third party payer) is: ______________________ per session

By your signature below you consent to the treatment offered herein, you agree to pay for your counseling services as indicated and at the time of service, and if you are using a third party (e.g. insurance) payer, you agree that our office may provide any information to your insurance carrier and managed care company necessary to consider, process, and approve payment of services. Further, you agree that all charges are, finally, your responsibility, and that in the event your insurance carrier refuses payment, you agree to pay all amounts due. Your clinician may refuse to schedule an appointment until you have paid any outstanding balance you have with our office. If you are unable to pay for your services in the future, you understand and agree that your clinician will be unable to continue services. In that event, your clinician will provide you with a referral to another provider more readily able to work within your budget.

___________________________________	____________	___________________________
Patient/Guardian Signature	Date	Clinician Signature

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Credit Card Authorization

Card Holder Name: ____

Billing Address: ____

____

Credit Card Number: ____

Expiration Date: ________________ Security Code (3-digit): __________

Amount to Charge: __________(USD)

I authorize Mindful Reflections Counseling Center, PLLC to charge the agreed amount listed above to my credit card provided herein. I agree that Mindful Reflections Counseling Center, PLLC may charge an $80 fee for missed or canceled appointments without 24-hour notice. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

___________________________ ______________________________
Cardholder Printed Name Cardholder's Signature

____
Date

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Authorization to Obtain, Release, and Exchange Clinical Information

Completing and signing this form will allow Mindful Reflections Counseling Center, PLLC to obtain, release, and exchange privileged, confidential, and protected information from your clinical record(s) to and/or from the person or entity you designate below.

Patient's Printed Name: ________________________________ Date of Birth: ___________

My signature below authorizes Mindful Reflections Counseling Center, PLLC to obtain, release, and exchange clinical information to and/or from:

Name: ____
Address: ____
____
____
Telephone: ____
Fax: ____
Email: ____

I want Mindful Reflections Counseling Center, PLLC to obtain, release, and/or exchange the following clinical information (as indicated by checkmarks below) contained within my patient/treatment/office records:

- ☐ Appointment dates
- ☐ Clinical interview information
- ☐ Progress/Therapy/Case notes
- ☐ Psychological assessment/test results
- ☐ Other: ________________________
- ☐ Psychological testing/assessment raw data (e.g., protocols, transcripts, worksheets, etc.)
- ☐ Any written opinions regarding the referral Question addressed in a psychological evaluation
- ☐ treatment planning / recommendations

This authorization will remain in effect until ____________________ or for 12 months from the date of signing, whichever is sooner.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Mindful Reflections Counseling Center, PLLC's office address. I further understand that my revocation will not be effective to the extent that Mindful Reflections Counseling Center, PLLC has taken action in reliance upon this signed authorization.

_____________________________________ ______________________
Patient or Guardian's Signature Date

_____________________________________ ______________________
Witness Signature Date

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Minor Demographic Questionnaire

A. Identification

Child's full name: ______________________________ Date of birth: ____/____/____

Nicknames: ______________________________

Child's legal guardian: ____________________ Person(s) completing this form: ____________________

Disability status: ______________________________ ☐ Talk about later

Gender identity: ______________________________ ☐ Talk about later

Sexual orientation: ______________________________ ☐ Talk about later

Racial/ethnic identities: ______________________________ ☐ Talk about later

Religious/spiritual traditions or identity: ______________________________ ☐ Talk about later

Other ways you identify your child and consider important: ______________________________

B. Family information

Mother/guardian: ______________________________ Age: ____

Best phone number: ____________________ Other phone number: ____________________

Address: ______________________________

Email: ____________________ Occupation: ____________________

Employer: ____________________ Location: ____________________

Father/guardian: ______________________________ Age: ____

Best phone number: ____________________ Other phone number: ____________________

Address: ______________________________

Email: ____________________ Occupation: ____________________

Employer: ____________________ Location: ____________________

Parents are currently: ☐ Married ☐ Divorced ☐ Separated ☐ Remarried to others ☐ Never married
☐ Other: ______________________________

Patient lives with: ☐ Mother ☐ Father ☐ Relative ☐ Guardian ☐ Other: ____________________

Who has legal custody* of this child? ☐ Mother ☐ Father ☐ Both/either/shared ☐ Relative
☐ Guardian ☐ Other: ______________________________

*Please bring custody or court papers to the first appointment if they exist.

Members of the household and other important persons in the child's life:

Name	Relationship	Age	Sex	Health, behavioral or learning difficulties?	Last grade in school completed, or works as a . . .	How does this person get along with the child?

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C. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: ______________________________ Phone: ______________

Relationship: ______________ Address: ______________________________

D. Referral

Who gave you my name to call?

Name: ______________________________ Phone: ______________________

Address: ____

How did this person explain how I might be of help to you? ______________________________

Is this person's relationship with you ☐ personal or ☐ professional?

If professional, may I have your permission to thank this person for the referral? ☐ Yes ☐ No

Should I consult with this person about the referral? ☐ Yes ☐ No

E. Current problems or difficulties

Please describe the main difficulties that led to your bringing this child to see me: ______________________

____

When did these problems start? ______________________________________

What makes these problems worse? ______________________________________

____

What makes these problems better? ______________________________________

____

With therapy, how long do you think it will take for these to get a lot better? ______________________

F. Development

1. Pregnancy and delivery

Prenatal medical illnesses or problems: ______________________________________

Maternal substance use: ☐ Alcohol ☐ Tobacco ☐ Medications ☐ Other drugs

Maternal stressors: ____

Was the child premature? ☐ No ☐ Yes, by ____ weeks. Birth weight: ____ Birth length: ____

Birth complications or problems? ______________________________________

2. The first few months of life

Breast-fed? ☐ No ☐ If yes, for how long? ________ Feeding problems? ______________________

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Allergies? ________________________________ Sleep patterns or problems: _______________________________

Relationship with mother: ____

3. Milestones

At what age did this child do each of these?

Sat without support: ________ Crawled: ________ Walked without holding on: ________ Helped when being dressed: ________ Ate with a fork: ________ Stayed dry all day: ________ Didn't soil his or her pants during day: ________ Stayed dry all night: ________ Tied shoelaces: ________ Buttoned buttons: ________ Slept alone: ________ Rode bicycle: ________

4. Speech/language development

Age when child said first word understandable by a stranger: ________ Said first sentence understandable to a stranger: ________

Any current speech, hearing, or language difficulties? ____

5. Any other current concerns about development? ____

____

G. Education

How many years of schooling has your child had (including preschool and kindergarten)? ____ years.

From (date)	To (date)	School's name and district	Teacher	Special classes or supports?	Did your child graduate?

May I call and discuss your child with the current teacher? ☐ No ☐ Yes If yes, phone number: _______________

H. Health and medical care

1. How is your child's general level of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Pediatrician/PCP/Clinic/doctor's name: ____

   Phone: _____________ Address: ____

   - If your child enters treatment with me for psychological problems, may I tell your child's medical doctor/PCP, so that he or she can be fully informed and we can coordinate your child's treatment? ☐ Yes ☐ No
   - If your child sees other doctors or clinics, please check here ☐ and write their names, addresses, and phone numbers on the back of this page.

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3. List all childhood illnesses, hospitalizations, medications, allergies, important injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	**Age, or from-and-to ages**	**Treated by whom? Mark the primary care provider (PCP) with a star.**	**Effects/outcome**

4. List *all* medications, drugs, or other substances your child has taken in the last year—prescribed medications, over-the-counter vitamins, supplements, herbs, and others.

Medication	**Dosage? And how often?**	**For what condition?**	**When started?**	**Effects/outcome**	**Prescribed and supervised by whom?**

5. Has your child ever received inpatient or outpatient psychological, psychiatric, drug or alcohol treatment, medications or counseling services before? ☐ No ☐ Yes. If yes, please indicate:

For what (diagnoses)?	**From (date)**	**To (date)**	**Name of doctor, provider, or agency and location**	**What kind of treatment?**	**With what results?**

6. Has any other family member been hospitalized for a psychiatric, emotional, or substance use disorder?
☐ No ☐ Yes. If yes, please indicate:

Name of family member	**For what (diagnoses)?**	**What kind of treatment?**	**From (date)**	**To (date)**	**With what results?**

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7. Describe any substance abuse or mental illness in family members (who, relationship, disorder, currently active?): _

___

8. Has the child had any residential placements, institutional placements, or foster care? ☐ No ☐ Yes. If yes, please indicate:

Age entered	Age left	Program's name	Reason for placement	Problems there

9. Other important family issues (losses, adoption, stepparents, other relatives): ___

___

I. Abuse history

Note: If I suspect that there is or has been abuse, I have to report that. Please be aware of this as you answer the questions below, or leave them blank.

❑ This child was not abused in any way. ☐ This child may have been abused.

J. Drug use by your child

1a. How many caffeine drinks are consumed by your child each day (coffee, tea, colas, energy drinks, etc.)?

1b. How often each week are medications (prescription or over the counter) or energy drinks or other chemicals used for alertness? ___

2. How much tobacco is smoked or chewed each week? Kind: ___ Amount ___

3. How many drinks of beer, wine, or liquor are consumed by your child in a typical week? ___

4. Did he or she ever drink to unconsciousness, or run out of money because of drinking? ☐ No ☐ Yes

5. Has your child ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ☐ No ☐ Yes. If yes, which and when? ___

6. Which drugs (not medications prescribed for the child) have been used in the last 5 years? ___

___

7. Do you think that your child has a drug or alcohol problem? ☐ No ☐ Yes. If yes, what kind? ___

___

K. Legal history

1. Does your child have any legal history? ☐ No ☐ Yes. If yes, please explain: ___

___

L. Friends of the child

How many? ___ Their gender: ☐ Only same ☐ Both ☐ Only other

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Their ages: ☐ About the same as my child ☐ Mostly older ☐ Mostly younger

Activities with friends: ____

____

Influence of friends on child: ☐ Positive ☐ Negative. Specifics: ______________________________

____

M. Other

Is there anything else that is important for me as your child's therapist to know about, and that you have not written about on any of these forms? ☐ Yes, and I have written about it on the back of this page or another sheet of paper.