Alex Lopez Counseling, MS, CRC, LPC-Associate
Supervised by F. Heath Smith IV, LCDC, LPC-Supervisor
801 W. Nolana Avenue, Suite 101, McAllen, Texas 78504

INFORMED CONSENT

WELCOME

Beginning counseling is an important and meaningful step, and I appreciate you choosing to begin this process with me. My goal is to provide a supportive and respectful space where we can work collaboratively toward your personal growth, healing, and overall well being.

This informed consent document is intended to help you understand my role as a Licensed Professional Counselor Associate, the counseling process, applicable state and federal laws, and your rights as a patient. Please review this information carefully, and feel free to ask any questions you may have. Open and honest communication is an important part of counseling, and I want you to feel informed and comfortable as we begin our work together.

THE THERAPEUTIC PROCESS

I view counseling as a collaborative process designed to support personal growth and improve overall well being. People seek counseling for many reasons, including addressing specific concerns, navigating life transitions, or gaining greater insight into patterns that may be impacting their mental, emotional, or relational health. Choosing to engage in counseling reflects strength and self awareness, and the process can help you better recognize your existing strengths while developing practical strategies to support positive change. My therapeutic approach is integrative and draws primarily from cognitive behavioral, motivational interviewing, solution focused, and person centered frameworks.

Counseling involves both potential benefits and risks. At times, discussing difficult experiences or examining unhelpful patterns may lead to temporary discomfort or emotional distress. However, counseling can also lead to meaningful improvements such as increased insight, improved relationships, greater emotional regulation, and progress toward personal goals. While outcomes vary and the process may not always meet expectations, counseling is intended to be a supportive and hopeful space for growth over time.

SERVICES OFFERED

I provide individual counseling services to adolescents and adults experiencing a wide range of concerns. I do not prescribe medication. If you need services that fall outside my scope of practice, I will assist with appropriate referrals and, with your consent, may coordinate care with other qualified providers.

During the initial session or sessions, I will gather information about your reasons for seeking counseling and your personal history. Based on this information, I will share initial impressions and collaborate with you to develop a treatment plan if you choose to continue. Treatment plans are tailored to your goals, abilities, and circumstances and are reviewed periodically to ensure they remain helpful and effective. You have the right to discontinue counseling at any time, and referrals to other providers are available upon request.

APPOINTMENTS CANCELLATIONS RESCHEDULING & MISSED APPOINTMENTS

When scheduling an appointment, please review your availability carefully to avoid conflicts. Appointment times are reserved specifically for you, and missed appointments or late cancellations result in lost opportunities for both the patient and the counselor. **To avoid being charged the full session fee, appointments must be cancelled or rescheduled at least 24 hours in advance or one business day prior to the scheduled appointment.** *For example, a Monday appointment must be cancelled by Friday.* Cancellations or rescheduling requests may be made by phone **(956-994-1428)**, voicemail, email, or by responding to the office text message provided to you. **Appointments that are missed or cancelled without adequate notice will be charged at 100% of the session fee.** While emergencies do occur, please make every effort to attend sessions as scheduled. If I need to cancel or reschedule an appointment, I will make every effort to notify you as soon as possible. If I am unavailable for an extended period of time, I will provide referral information to ensure continuity of care if needed.

Initial here if you read and understood page 1:_____

PROFESSIONAL FEES & PAYMENT

- $150.00 for a 60 to 90-minute Initial Evaluation ($25.00 for every 15 minutes after 90 minutes)
- $100.00 for the therapeutic 60 minute session ($25.00 for every 15 minutes thereafter)
- $50.00 for a 30-minute session ($25.00 for every 15 minutes thereafter)
- $25.00 additional (hourly) fee for consultations scheduled during non-operating office hours
- Services listed below are based on standard counseling rates
  - Telephone consultations (more than 14 minutes), Longer sessions
  - Report or letter writing to school(s)/teachers, physicians, psychiatrists, etc.
  - Site visits/Travel time
  - Meeting attendance or phone consultations with other professionals (that you requested/authorized)
  - Preparation of records or treatment summaries

Payment is due prior to securing an initial appointment and may be made by cash in the exact amount, debit card, or credit card. As a Licensed Professional Counselor Associate, I do not accept or bill insurance plans. All services are provided on a self pay basis. **Once services have been provided, fees for those services are nonrefundable.**

GOOD FAITH ESTIMATE

Under the No Surprises Act, you have the right to receive a Good Faith Estimate of expected charges for counseling services when you are self paying. The Good Faith Estimate outlines the anticipated cost of services and is available upon request and prior to the start of services. Actual charges may vary depending on the length, frequency, or duration of services. Payment of any outstanding balance is required before scheduling additional appointments. Fees for services already provided are nonrefundable.

RECORDS AND CONFIDENTIALITY

A clinical record is maintained for each patient and may include identifying information, session notes, relevant reports from other professionals, correspondence you provide to me, and copies of communications sent on your behalf. These records are used as a working document to support, guide, and document the counseling process. Counseling services are confidential, with limited exceptions as outlined below.

Confidentiality may be broken only in the following circumstances:

1. If I believe there is an imminent risk of harm to you or others;
2. If I have reason to suspect abuse, neglect, or exploitation of a child, elderly person, or individual with a disability;
3. If disclosure is required by state or federal law or court order;
4. If you provide written authorization through a release of information;
5. For purposes of professional supervision or consultation, during which identifying information is minimized; or
6. As otherwise described in the HIPAA Notice of Privacy Practices.

EMERGENCIES

While I make every effort to respond to messages within 24 hours, I do not provide emergency or crisis services. If you are experiencing a mental health emergency or are at risk of harm to yourself or others, please call 911, contact the 988 Suicide and Crisis Lifeline by calling or texting 988, contact the Tropical Texas Behavioral Health crisis hotline at 877-289-7199, or go to the nearest emergency room.

COMMUNICATION AND ELECTRONIC CONTACT

Email and text messaging may be used for administrative purposes such as scheduling, rescheduling, and appointment reminders. These methods are not appropriate for discussing clinical concerns, therapeutic issues, or emergencies. Electronic communication may not be fully secure, and while reasonable efforts are made to protect your privacy, confidentiality cannot be guaranteed when using email or text messaging. In accordance with professional and ethical standards, I do not engage with current patients on social media platforms, and this boundary extends for a two-year period following the termination of counseling services. **You will receive communication by phone, text message, or email for appointment reminders or necessary administrative matters.** Please contact emergency services or crisis resources for urgent concerns rather than using electronic messaging.

Initial here if you read and understood page 2:_____

NOTICE OF PRIVACY PRACTICES AND CLIENTS' RIGHTS
I/we have reviewed the office's Notice of Privacy Practices, which explains how me and/or my dependents medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____/_____ _____
Print Name of Patient and Legal Guardian (if under 18) Guardian's Relationship to Patient

_____ _____
Signature of Patient OR Legal Guardian Date

CONSENT FOR TREATMENT OF MINORS
(complete this section ONLY if the patient is under the age of 18)

This section applies only when the patient is under the age of eighteen and is not legally emancipated. Under Texas law, parents or legal guardians generally have the right to access their minor child's treatment records in accordance with the Texas Family Code and other applicable state and federal laws. Access may be limited when disclosure is believed to place the minor at risk of harm or when an alternative arrangement is agreed upon in writing.Because privacy is often essential to effective counseling, particularly with adolescents, parents or legal guardians may be asked to consent to limited access to session content. When such an agreement is in place, communication will typically be limited to information regarding attendance, general progress, and participation in treatment. If a minor shares information that would be important for a parent or guardian to know, I will encourage the minor to share this information directly and may offer to facilitate that conversation. Confidentiality will be broken if there is reason to believe the minor is at risk of harm to self or others, or as otherwise required by Texas law, including mandatory reporting of abuse, neglect, or exploitation. By signing below, the parent or legal guardian and the minor acknowledge and agree to these terms.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Patient Date

ACKNOWLEDGEMENT

(Signature required for treatment/Firma requirida para el tratamiento.)

My signature(s) below indicates that I have read this document and agree to treatment based on my informed wish to proceed with services.

_____
Name of Patient (PRINT legibly)

_____
Print Name of Parent/Legal Guardian (only needed if patient is under 18 years of age)

_____
Signature of Patient OR Parent/Legal Guardian
(signature of parent/legal guardian required if patient is under 18 years of age)

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DEBIT/CREDIT CARD AUTHORIZATION
(This information will remain confidential)

I authorize The Sendero Group, PLLC, dba Counseling Office of F. Heath Smith IV, to charge the card(s) on file for services rendered to me and/or my dependents which include appointments (face-to-face or telehealth), lab orders, report or letter writing requested by me/my dependents, phone consultations with other agencies/professionals and or preparation of records, etc. Additionally, I authorize The Sendero Group, PLLC, dba Counseling Office of F. Heath Smith IV, to charge the card(s) on file for appointments made by me and/or my dependent(s) not honoring the 24 hour cancellation/reschedule policy including appointments scheduled on Monday which require a one business day cancellation/reschedule notice (cancel appointment on Friday for appointment scheduled on Monday). I understand this includes missed/no show appointments.

_____

PRINTED Name of Cardholder (print the person's name exactly as it appears on the card)

_____

Hand-written Signature of Cardholder (cardholder's signature authorizes our office to run the card)

_____ _____

Name of Patient (if different than the cardholder) Relationship to Patient

Cardholder's email (where we will email the receipts)**:**
_____

Cardholder's Mobile Number: _____

Debit/Credit Card Type: ▫ Discover ▫ MasterCard ▫ Visa ▫ American Express

PRINT DEBIT/CREDIT CARD NUMBERS LEGIBLY

Debit/Credit Card Number: _____

Expiration Date: _____ CVV Code: _____ (AMEX requires a 4-digit code)

Cardholder's Billing Address: _____

_____

_____

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INTAKE FORM

WELCOME! The information you provide is confidential and will be helpful for you and your counselor when you meet for the first time.

Patient Information: (**PRINT** clearly)

Name: _____ Sex: Male_____ Female_____

Social Security No.: _____ Age: _____ Date of Birth: _____/_____/_____

Mailing Address: _____ City, State & Zip Code: _____

Home Phone: _____ Patient's Cell. Phone (including minors):_____

Email (please **print** clearly): _____

Ethnicity: _____ Where did you grow up? _____

Education: _____ Occupation: _____

What is your religious background/involvement? _____

List emergency contact person: Name: _____ Cell:_____

Person financially responsible for the patient's account (List the contact information of the individual that will pay for the office visits):

Name:_____ Relationship to Patient:_____

Mailing Address: _____ City, State & Zip:_____

Mobile Phone:_____ Home Phone:_____

Additional Patient Information List Closest Relationships - What persons do you consider closest to you? (e.g.: dad, mom, spouse, children)

Name	Date of Birth/Age	Relationship	Lives with you?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Please describe your current living arrangement (e.g., Do you live with others?): _____

_____

Have you participated in any of the following? Counseling ☐ Yes ☐ (Life) Coaching ☐ Yes ☐ No Substance Abuse Counseling ☐ Yes ☐ No

If yes, when and why? _____

Are you currently seeing a psychiatrist, therapist, or helper? ☐ Yes ☐ No

Have you or a family member ever been hospitalized for a mental or emotional illness? ☐ Yes ☐ No

If yes, please explain: Date(s): _____ Location: _____

Reason: _____

Substance abuse/addiction history? ☐ Yes ☐ No If yes, please explain: _____

_____

Legal History – List arrests, prison, DWI, DUI, Public Intoxication (include year):_____

_____

Medical Information: Doctor's name and phone number: _____

Are you on any medications? ☐ Yes ☐ No If yes, what medication(s) and for what reason? _____

_____

Have you had a serious illness, injury, operation, or hospitalization? ☐ Yes ☐ No

If yes, please explain:_____

Do you have a history of asthma, seizure disorder, head injury, concussion, or heart problems? ☐ Yes ☐ No

If yes, please explain:_____

Purpose of Visit

Tell me, in your own words, why you are here today? (Porque esta aqui?) _____

_____

_____

_____

_____

_____

What are the two (2) most important goals for therapy? (Indique 2 metas mas importantes de terapia para usted.)

1. _____

2. _____

Problem/symptom checklist. Place a number next to **ALL** symptoms/problems: 0 = none, 1 = mild, 2 = moderate, 3 = severe

_____ marriage	_____ divorce/separation	_____ alcohol/drugs	_____God/faith
_____ pre-marital	_____ child custody	_____ other addictions	_____ church/ministry
_____ being single	_____ disabled	_____ grief/loss	_____ past hurts
_____ sexual issues	_____ work/career	_____ depression	_____ codependency
_____ family	_____ school/learning	_____ fear/anxiety	_____ intimacy
_____ children	_____ money/budgeting	_____ anger control	_____ communication
_____ parents	_____ aging/dependency	_____ loneliness	_____ self-esteem
_____ in-laws	_____ weight control	_____ mood swings	_____ stress control

_____Other:_____

Family Information:

Marital Status: Single _____ Dating _____ Committed relationship _____ Engaged _____ Married_____ (# of years? _____)

Separated_____ (how long? _____) Divorced_____ (how long?_____) Widow(er)_____

Spouse's Name (if applicable) _____ Age _____ Occupation _____

I would describe my friendships as: Close _____ Somewhat close_____ Distant_____ Conflicted_____

I would describe my relationship with my mother as: Close _____ Somewhat close_____ Distant_____ Conflicted_____

I would describe my relationship with my father as: Close _____ Somewhat close_____ Distant_____ Conflicted_____

How many brothers and/or sisters do you have? _____ How would you describe your relationship? _____

CRISIS INFORMATION:

For emergencies, call 911. If you are in crisis, contact the Suicide & Crisis Lifeline by calling or texting 988.

Are you having any current suicidal thoughts, feelings, or actions? Yes_____ No_____

If yes, please explain: _____

Any current homicidal or violent thoughts or feelings, or anger-control problems? Yes_____ No_____

If yes, please explain: _____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Yes_____ No_____

If yes, please explain: _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss)? Yes_____ No_____

If yes, please explain: _____

Who referred you to this office? (physician, counselor, employer, self-referral) _____

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____