dba **Counseling Office of F. Heath Smith IV**
801 W. Nolana Avenue, Suite 101 • McAllen, Texas 78504

INFORMED CONSENT

WELCOME

You have taken the important first step to pursue counseling with F. Heath Smith IV, Licensed Professional Counselor and Licensed Chemical Dependency Counselor. As a licensed clinician of over 30 years, I have broad experience with many life issues that have negatively affected an individual's ability to thrive. Educationally, I have pursued my passion in professional and faith-based counseling with Master's Degrees in both disciplines.

I realize that starting counseling is a major decision, and you may have many questions. This document contains valuable information about my professional services, state and federal laws, and your rights. If you have any questions about what is stated in this document or about something that is not covered in this document, please ask me so that we can discuss your questions.

THE THERAPEUTIC PROCESS

I view counseling as a way to enrich your life. Counseling can improve your physical, mental, and spiritual wellbeing as well as your relationships with others. You may have specific issues to address or just want to enhance your day-to-day living. While some people believe that seeking out counseling signals weakness, I wholeheartedly believe that seeking counseling for oneself exhibits tremendous strength. Counseling can serve to further uncover your strengths and help provide strategies about ways to employ them. My approach to counseling could be best understood as an eclectic theoretical framework with a predominant orientation towards cognitive behavioral paradigms.

The therapeutic process can have many benefits and risks and it is important to consider both when making any treatment decision. Addressing uncomfortable subject matter or confronting unhealthy behavioral patterns may cause increased distress for a period of time; however, counseling has been shown to have many benefits including improved relationships, a significant reduction in feelings of distrust and resolution of specific problems. While not all of the therapy may meet your expectations, and your symptoms may be more pronounced at different points during the course of therapy, therapy is hopeful work.

SERVICES OFFERED

I am trained and experienced in counseling individuals, couples, families, and groups. I provide counseling to adolescents and adults presenting with a wide range of issues. I do not prescribe medication. If you or a family member requires services that I cannot provide, I shall assist you in a referral, and with your permission, coordinate services with the specialty provider.

In our initial session(s), I will gather information about your reasons for pursuing counseling and take a personal history. After the evaluation session(s), I will be able to offer you some first impressions of what our work together will include and a treatment plan to follow if you decide to continue counseling with me. We will work together to devise a counseling plan that offers reasonable promise of success and is consistent with your abilities and circumstances. We will regularly review the plan to ensure its continued viability and effectiveness. At any time, you have the right to terminate counseling. If at any time you would like a referral to another psychotherapist, I will provide one.

APPOINTMENTS (CANCELLED, RESCHEDULED, MISSED APPOINTMENTS)

When scheduling an appointment with our office, please check your calendar to avoid conflicts in schedule (work, doctor's appointments, school, vacation, etc.) as missed appointments *will be* charged for the reserved time. **To avoid being charged for a scheduled appointment** (reserved time) whether initial or follow-up, the appointment **must be cancelled and/or rescheduled no less than 24 hours prior to the scheduled appointment date/time and one business day in advance (cancel appointment on Friday for appointment(s) scheduled on Monday)** by calling the office at 956.994.1428 (and leaving a message on the confidential answering machine). A missed appointment is a lost opportunity for both the patient and counselor. The counselor has reserved that time for the patient. Other patients have not had access to that appointment time because it was held for you. In addition, your counselor considered the appointment time an important part of your counseling. While unforeseen emergencies do occur, please make every effort to keep your appointment as scheduled. When, on occasion, I will be unavailable for appointments, I will make every attempt to inform you of this in advance. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Initial here if you read and understood page 1:_____

PROFESSIONAL FEES & PAYMENT

- $262.50 for a 90-minute Initial/Comprehensive Diagnostic Evaluation ($43.75 for every 15 minutes after 90 minutes)
- $175.00 for the therapeutic hour/session ($43.75 for every 15 minutes thereafter)
- $87.50 for a 30-minute session ($43.75 for every 15 minutes thereafter)
- $1,100.00 for Professional Licensure Evaluations (TMB, TXPHP, TSBP, TPAPN, etc.)
- $450.00 for Pharmacy Tech. Evaluations
- $500.00 for DOT/NONDOT/Driver's License Evaluations
- Labs priced per order/Additional $50 (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 teachers, physicians, psychiatrists, etc.
    - Site visits/Travel time
    - Meeting attendance or phone consultations with other professionals (that you have authorized)
    - Preparation of records or treatment summaries

Payment by cash (exact amount), debit card or credit card **is due prior to securing an initial appointment**. This office does not work directly with any insurance carriers. If you would like to submit an itemized receipt to your insurance carrier for out-of-network reimbursement, please let the office know and I will provide a mental health diagnosis***, if applicable***, for insurance purposes. Any diagnosis given creates a public record of a mental health/substance use condition. Your signature gives me permission to communicate with your insurance carrier which, in turn, means your/your dependent's counseling is not confidential. Your insurance carrier will determine how many sessions it will cover for the diagnosis. In addition, there are some mental health/substance use services that many insurance carriers do not cover. It is your responsibility to check with your insurance carrier, prior to your appointment, to determine if the services provided by me will be covered. Payment of outstanding balance(s) is required prior to scheduling a follow-up appointment. **Once services are performed, refunds cannot be made for services rendered**.

CONFIDENTIALITY

Records are maintained on each patient. Records may contain the following: identifying information; session notes; any reports from other professionals regarding your treatment; any correspondence or other materials that you send to me; copies of any correspondence about you that I send to others. These records are meant to be a working document to both reflect and guide your therapeutic work. Your counseling is confidential ***except*** in the following circumstances:

1) If you choose to seek reimbursement for counseling from your insurance provider, I will communicate about your counseling with your insurance provider.
2) If I have reason to believe that you may harm yourself or others.
3) If I have reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability or
4) If I am ordered to disclose by state or federal courts.
5) If you sign a release of information for me to communicate with someone else.
6) Information necessary for supervision or consultation.
7) Information noted in the HIPAA Notice of Privacy Practice.

EMERGENCIES

While I will always try to return your call or email within 24 hours and usually sooner, I am not an emergency mental health/substance use service. If you experience an emergency, you should call 911, call the crisis Tropical Texas Behavioral Health hotline at 877-289-7199 or go directly to your nearest emergency room.

OUT OF OFFICE COMMUNICATION

Email and text message communication can be a convenient means of setting and confirming appointment times through the office staff, but this office will not use email or text message communication as a forum for discussing serious psychotherapeutic issues. Email or text message communication may not be a secure way of sending and receiving information, and while I make every attempt to keep my emails and text messages confidential, you may not hold The Sendero Group, PLLC, F. Heath Smith IV or staff liable for any breach of confidentiality that results from the use of email or text message communication. The ethics of professional counseling do not allow for social media contact with patients that are actively involved in psychotherapy and, additionally, for a two-year period following termination of services. <u>You will be contacted via telephone, text message and/or email as a *courteous reminder* of upcoming appointment(s) and/or for requests of communication</u>.

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 patient is under the age of 18)

Patients under 18 years of age who are not emancipated, and their guardians should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child, or we agree otherwise. Because privacy in counseling is often crucial to successful outcomes, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. If the child reveals something to me that I believe that child should tell the parents, I will request that the child tell the parent(s) in my presence. I will notify the parents if I believe the child is a danger to himself/herself or others. The patient and parent/guardian should sign below if (s)he agrees with this statement.

_____ _____

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 (P R I N T 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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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 name exactly as it appears on the card)

_____

Hand-written Signature of Cardholder (authorizing our office to run your card)

_____ _____

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

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

Cardholder's Mobile Number: _____

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

PRINT CREDIT/DEBIT CARD NUMBERS **LEGIBLY**

Credit Card Number: _____

Expiration Date: _____ CVV 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: (**P R I N T** 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 (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	Birth Date/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 Y/N (Life) Coaching Y/N Substance Abuse Counseling Y/N

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 your 2 most important goals for the session? (Indique 2 metas importantes 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: _____