**Sherry R. Latson, Ph.D.**

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**Patient Rights and Responsibilities**

**Introduction and Professional Disclosure**

**I am a licensed profession counselor and supervisor. I have a Ph.D. from University of North Texas. I am currently a counseling professor at Amberton University. I have also been a school counselor for Garland ISD, Hockaday School, and Richardson ISD. I counsel adults, adolescents and children. I use play therapy for children and Adlerian counseling for adults, adolescents and families.**

**Nature of Counseling**

**I believe that individuals seek counseling to improve their quality of life. Goals will be set collaboratively. I will be using active listening to understand your view of life and your feelings. We will work together to help achieve the goals we set for you and/or your family.**

**Play therapy is used with children. Play therapy is designed to allow children to express feelings and thoughts through their natural medium of communication- play. Parents will be involved in the treatment process through parent education, consultation and family counseling.**

**Effects of Counseling: At any time, you may initiate discussion of possible positive or negative effects of entering, exiting, or continuing counseling. Benefits are expected from counseling, but specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life and perspectives. These changes may affect significant relationships, your job, or understanding of yourself. If these changes are distressing, let me know, so that we can work together to achieve the best possible results for you.**

**Client Rights: Some clients need only a few sessions, and other may require months or even years of counseling. As a client, you are in complete control and may end our counseling relation at any time. But, please participate in a termination session. You also have the right to refuse or negotiate any of my suggestions for you or your children.**

**Consultation with other Professionals: If you would like me to consult with previous therapists, physicians, psychiatrists or school personnel, please sign a release that enables me to communicate with other professionals.**

**Polices**

**I would like to welcome you to my office. Please take a minute to read through these rights and responsibilities so that you have a clear idea of my policies. If you have questions, please feel free to ask. Please initial in each space to indicate that you understand and agree to the item.**

**\_\_\_Counseling Relationship: This is a professional relationship rather than a social one. Our contact will be limited to counseling sessions. In an emergency, you may contact me on my cell phone. Please do not invite me to social gatherings, offer me gifts, ask me to write a reference for you, or ask me to relate to you in any way other than the professional context of our sessions. I will not “friend” current or former clients on social media. To protect your confidentiality in public, I will not acknowledge you unless you approach me first.**

**\_\_\_\_Both parents must agree to counseling for a minor child.**

**Scheduling and Appointments:**

**\_\_ All clinical services are by appointment only. Since I work limited hours, it is important that you make your appointments carefully and make every effort to keep them. You may call or text me at 214—228-9417 at any time to notify me of a cancellation or change. Barring emergencies, please cancel at least 24 hours prior to your scheduled time.**

**\_\_\_Therapy sessions are 45 minutes in duration. If I am running late, I will still give you 45 minutes (or work out a mutually acceptable solution). If you are late for your appointment, you will be allowed 45 minutes from the time set for your appointment.**

**Financial**

**\_\_\_ Patients are responsible for payment of all fees (or co-pays) at the time of the visit.**

**\_\_\_If you do not show up for an appointment or cancel your appointment, giving less than 24 hours prior notice, then you will be charged for the time scheduled at a rate of $120 per hour. Charges for “no shows” cannot be billed to insurance companies.**

**\_\_\_There will be no charge for telephone calls pertaining to business matters such as scheduling, payment of fees or insurance related questions. There will be a charge if you call for a professional consultation requiring more than 5 minutes of time. If you require a longer consultation, there are two alternatives. You may set up a phone conference, or request an emergency appointment. The fees for a phone conference cannot be billed to insurance companies. Consultation with other professionals (school, physician, etc.) are billed at the same rate. Telephone consultation fees- $25 per 15 minutes. In the case of an urgent need, additional office appointments can also be arranged.**

**\_\_\_\_Returned checks will be assessed a fee of $25.**

**\_\_\_For client who use managed health care plans, you may need to be pre-certified in order for insurance to cover your therapy. You are responsible for obtaining the initial authorization from your insurance carrier. I will obtain additional authorizations, if required.**

**\_\_\_The fee for court appearance, reports, etc. will be billed at $200 an hour. It is understood that travel time and time waiting for the appearance is also billable, and is not covered by insurance.**

**Emergencies:**

**\_\_\_ I have a cell #214-228-9417 where you can leave messages that are not urgent. I check the voice mail regularly throughout the day, and will return your call as soon as possible. If you have an emergency, call my cell or text at 214-228-9417. If the concern is potentially life threatening, do not wait for a call back, but proceed to an emergency room or contact your physician.**

**Confidentiality**

**\_\_\_Privacy and confidentially are of the utmost importance to me. Please be aware of the limits of confidentially. Limits include, but are not limited to cases of possible abuse, threat of harm to self or others, court orders, child custody litigation or filing of a complaint. If you would like me to contact a physician, school, etc. please complete the release of information form. If any records are subpoenaed, I will provide the requested information, whether or not the information is favorable to the undersigned.**

**\_\_\_Children also have the privilege of confidentiality. Please allow your child the opportunity to talk with me about issues openly. Do not ask what they talked about in the session, but allow them to share what they wish. I will share information that is critical (abusive situations or life threatening conditions) or information that the child gives me to permission to share.**

**\_\_\_Please be aware that email transmissions may not be secure. Limit information transmitted via electronic means. I will not respond to clinical questions on text messages.**

**\_\_\_\_Records: Records are maintained for five years after the last counseling session. If I die or become incapacitated, my records will be handled by a designed professional counseling colleague.**

**Court appearances:**

**\_\_\_ I have not been trained in custody evaluations. If you feel you might need these services, I will be happy to refer you to therapists who specialize in that field. I believe it is important that children feel they have a place to talk openly about their feelings. If the content of their sessions then becomes a part of the court proceeding, then I have betrayed the child’s confidence.**

**Complaints and Grievances:**

 **\_\_\_ I would like to have the opportunity to address any of your concerns. However, if you have a grievance that is not resolved, you may file a complaint with the Board of Licensed Professional Counselors, 1100 W. 49th Street, Austin, TX 78756-3183.**

**\_\_\_ Defamation: By signing this intake and consent form, you agree that you will not make defamatory comment about the undersigned therapist to others or to post defamatory commentary about the therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others acting in concert with you, you further consent by signing this intake and consent form below to allowing the therapist to use confidential information necessary to rebut or defend against, or prosecute claims for the defamation.**

**Consent for Treatment**

**I voluntarily agree to receive (or agree for my child to receive) Mental Health care, treatment or services and authorize the undersigned therapist to provide treatment or services as are considered necessary and advisable.**

**I understand and agree that I will participate in the planning of my care (or for my child’s care) and I may stop such care, treatment by the undersigned therapist at any time.**

**By signing this form, I the undersigned, acknowledge that I have read, understood and agreed to be bound by the conditions, and information it contains. I acknowledge that I may ask questions or seek clarification of anything unclear to me.**

**I look forward to working with you and/or your family.**

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**Signature of client or parent (if client is a child) Signature of other parent (if client is a child)**

**Signature of therapist Date**

**I give permission for Dr. Latson to communicate with the following professionals about my (or my child/ren) about treatment:**

**Name: Phone:**

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**Signature of client or parents: Date:**

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