

Intrinsic Motivation Counseling Services, LLC

6510 Abrams Road, Suite 280

Dallas, TX 75231

Ph. 469-225-9551

Information & Consent Form

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating that you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Andrea Wise-Brown, LPS, NCC offers an array of counseling services, including individual, family, couples, group and consulting services. I am a skilled and experienced Licensed Professional Counselor. Effective psychotherapy is founded on mutual understanding and good rapport between client and Therapist. It is my intent to convey the policies and procedure used in my practice, and I will be pleased to discuss any questions you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, however, it is my desire to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: I provide counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which we will determine your concerns, and if both agree that I can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you, services to you may be terminated.

My goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and I are not a good fit, please discuss this matter with me to determine if transferring to a more suitable Therapist is right for you. If you decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions are available if determined appropriate by your counselor. If you must cancel or reschedule your appointment, we ask that you call Andrea Wise-Brown at 469-225-9551 at least 24 hours in advance. This will free your appointment time for another client. However, if you do not cancel in the appropriate amount of time you will owe Andrea Wise-Brown the entire fee for the session that is missed.

FEE SCHEDULE:

Diagnostic & Evaluation Session (1 st visit)	\$175.00
Couples (1 st visit 90 min / Ongoing 60 min)	\$175.00 / \$150.00
Regular Office Visits (50 minutes) (Individuals)	\$150.00
Family Sessions (90 minutes)	\$175.00
Outside Office Work (inpatient visits, court, collaborative law services)	\$300.00 per hour
Written Reports - insurance companies, supervisors, etc. pro-rated at:	\$300.00 per hour
Returned check fee per check	\$35.00
Smart Girls With Character	\$35.00 per session

*** A reasonable fee will be charged for copies of any records requested by the Client. ***

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. I request that payment be made before your session begins. If you are not using a Managed Care/PPO/EAP insurance plan and wish to file your own claim, I expect full payment at the time of service, and I will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact me regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer other options. It is not always possible to return a call immediately. Please utilize this phone number in the event of a crisis, and I will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: Andrea Wise-Brown follows all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the *Notice of Privacy Practices* provided to you.

Discussions between a Therapist and a client are confidential. 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: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this *Information and Consent Form*, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: 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:

Name

Telephone Number

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or deliver those records to another Therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client *Information and Consent Form* as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address and questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

Note: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Andrea Wise-Brown will not render services to your child until she has received and reviewed a copy of the most recent applicable court order.

Signature – Client/Parent

Date

Signature – Spouse/Partner/Parent

Date

Therapist

Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

Client/Parent

Date

I authorize the payment of medical benefits to the provider of services.

Client/Parent

Date

Social Media Addendum

To preserve the integrity of the therapeutic relationship and protect confidentiality I will not accept any requests for “friendship,” business contacts, direct or @replies, blog responses or requests for a blog response, etc. within social media sites. Any attempts to connect with Andrea Wise-Brown on social media sites will be ignored and addressed subsequently in treatment. If a client has not been formally informed of these boundaries prior to the Therapist (Andrea) receiving the request, the Therapist will ignore the request via social media site and explain why in subsequent interaction with the client.

Signature – Client/Parent

Date

Signature – Client/Parent

Date

Therapist

Date