GPS Counseling, LLC
Georgia P. Smith-Lyle, MA, LPC-Supervisor
985 CR 25780
Petty, Texas
469-855-0256,

INFORMATION AND CONSENT STATEMENT

This document contains important information about the counseling services that will be provided to you as a client. Please read all the information carefully and ask any questions you may have about the content of this document. It is my full intent to provide the best possible counseling services to meet your particular and individualized need. Upon signing this consent form, it will constitute an agreement between you and your counselor.

EDUCATION:

Amberton University, Garland, Texas, MA
University of North Texas, Denton, Texas, BA

CERTIFICATION:

Licensed Professional Counselor in the State of Texas

INTENT AND NATURE OF COUNSELING

You have the right to choose alternatives and to participate in designing your treatment plan. My guidelines for creating a treatment plan incorporate an approach to counseling which takes into account the spiritual, psychological, social and biological dimensions of a person. The therapeutic relationship which we establish will be characterized by respect and cooperation. One of my goals is for you to grow, develop and within a reasonable length of time come to a place of competence where, with God's help, you can discern, process and resolve your own problems without my assistance or intervention. I will offer you vehicles, principles and methods which you can utilize in the achievement of this goal.

Psychotherapy has possible risks as well as benefits. There may be times when you feel uncomfortable (certain feelings of sadness, guilt, shame, anger, anxiety, etc.). When dealing with trauma, deep hurts, or issues/crisis you may also experience unpleasant feelings. It is my intent to bring emotional healing as quickly as possible for you, but at the same time being sensitive and cognizant of what you are experiencing at the moment. I will attempt to counsel you at a pace that is most effective for you. You will experience release, freedom and a sense of well being as I begin to help you with the issues/desires that brought you here to begin with.

Because our sessions may be very intense psychologically, it is important that we acknowledge that we have a professional relationship rather than a social one. Our contact will basically be limited to the sessions you arrange with me although there certainly be times when our paths will cross, particularly if we are members of the same church, committees or attend the same social function. Please limit our interaction to the function in which we are involved at the time and save our therapeutic relationship for our weekly sessions.

You will learn a great deal about me personally as we work together during your counseling experience; however, it is important for you to remember that you are experiencing me largely in my professional role.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. You are entitled to an explanation of your condition and the treatment that will be provided as well as the duration and adverse risks involved. Please note that it is impossible to guarantee any specific results regarding your counseling goals; however, together we will work to achieve the best possible results for you.

CONFIDENTIALITY:

The information which you tell me belongs to you, not to me; therefore, I will keep confidential anything you say to me with the following exceptions: (a) you direct me, in writing, to tell someone else; (b) I determine you are a danger to yourself or others; (c) I am ordered by a court to disclose information; (d) for supervision/consultation purposes; or (e) for backup coverage when I am not available. Please note that I am bound by my Ethical Code to contact the nearest of kin and /or proper authorities if, in my opinion, a person is deemed to be a threat to himself or to others. I am required, by law, to report incidences of physical or sexual abuse of a minor or of the elderly.

This office may use and disclose medical information and financial information related to your care that may be necessary now or in the future to facilitate payment of third parties for services rendered to me. Guidelines for such disclosures will comply with the Health Insurance Privacy Practices Act. I am legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms.

It will be necessary for you to sign consent for release of information in the event you want any information released to another individual.

REFERRAL POLICY:

The process of helping you address specific areas of your life is unique. It inevitably is the catalyst for several personal issues to arise that may cause some discomfort. This is a normal and natural part of the relational process occurring between us. As the person chosen by you to be involved in this process, I will help you work through this discomfort. To this end I anticipate and desire a productive professional relationship with you.

If I believe that I do not have sufficient training or expertise to appropriately guide your treatment, I will refer you to someone who can.

In the event that a particular dissatisfaction with my services should arise, I am willing to discuss the nature of your dissatisfaction and make an attempt to move toward a solution acceptable to both of us. If we are unable to arrive at an acceptable solution, I will provide you with several possible referral sources.

FINANCIAL POLICY AND FEE ARRANGEMENTS:

Each session will be 55 minutes to an hour long. Depending on your need and progress, will depend upon the number of sessions suggested. An evaluation will need to be taken to determine how best I can help you. This evaluation may take up to 2 sessions. An assessment of your particular needs will then be made and discussed with you. A fee for each session will be assessed according to each hour session. If for some reason you need to contact me by phone for counseling, a fee will also be assessed according to the portion of time we are on the phone.

You have the right to know about any fees that you may be charged for services before those services are delivered and a full explanation concerning fee policies. My initial counseling session is an hour and fifteen minutes and my fee for the initial session is $165.00. The sessions after the initial session are 55 minutes to an hour and the fee is $145.00 per session. If there is an immediate issue that needs to be discussed with me and you are unable to come into a session, I can schedule something by phone, email or skype and I will prorate the session according to the time spent. I will provide you with an invoice if you choose to file the session with your insurance company. The invoice will provide you with all the information you need concerning the session to file your claim. Payment options are available which we will discuss during the visit if needed. Your insurance will be considered a part of your ability to pay. **I am always willing to work with you concerning arrangement for payment.** In return for a fee of $145.00 per 55 minute session, I agree to provide counseling services for you. The fee for each session will be due and must be paid at the conclusion of each session unless otherwise arranged. Cash or personal checks made payable to GPS Counseling, LLC are acceptable for payment. I also accept major credit cards and Zelle.

There will be a charge for my time spent outside of session, such as court appearances as an expert or regular witness or for other reasons, letters of recommendations, depositions or observational school visitations. I require a $500.00 retainer for all court and legal-related services. My fee for services related to anything legal is $150.00 per hour. This includes preparation, depositions, time spent in court, and testimony given.

CANCELLATION POLICY:

In the event that you will not be able to keep an appointment, you must notify me 24 hours in advance. If I receive less than 24 hours advance notice of cancellation of a scheduled session, you will be obligated to pay a sum of money equal to one half the amount for the session you missed. If you fail to show up for the appointment and no advance notice is given, you will be responsible for paying the full fee for the session that you missed.

RECORDKEEPING PROCEDURES:

It is a requirement by law and the standards of the counseling profession that records are kept. As the client, you have the right to your records, and a copy of which will be given to you upon your request. The therapist may choose to give you just a summary of the sessions. If you desire to see or listen to your records, it is best that you do so with your therapist present so that any questions that arise can be answered then. Remember, this can be a very emotional experience for you and I desire to make this transition in your life go as smooth as possible. If you are younger than 18 years old, the law requires that parents have the right to your records upon their request. However, at the consent of the parent I would ask that information discussed with your child in sessions be kept confidential between your child and counselor, as this seems to enhance the counseling effectiveness for children. The exception to this is if I foresee that your child is a danger to self or others then you will be informed, or in cases of sexual abuse. General information will only be given to parents in the instance that they agree to this arrangement. All treatment to minors will only be done with the consent of a parent or legal guardian.

If you have any questions, feel free to ask. Please sign and date this form to indicate that you have read, understand and consent to the information contained in it. My licensing requires me to give you phone number of Texas State Board of Licensing if you need to contact them for any reason (512-834-6658). Thank you for allowing me to help you and I look forward to our session(s).

_____ _____

Georgia Smith-Lyle, M.A., LPC-S Client's signature

Date_____ Date_____

GPS Counseling, LLC
Georgia Smith-Lyle, Licensed Professional Counselor-Supervisor

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This notice describes how medical and mental health information about you may be used and disclosed and how you get access to this information. Please read carefully.

This office may use and disclose medical and mental health information and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be release to insurance companies, HMO's, PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical/counseling records may be delivered to another physician, or any other physician that is directly or indirectly responsible for your medical care of the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. However, in certain cases where a person is or has been a danger to him or herself, or to others, we are required to notify appropriate parties.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health and mental health information. You have the right to have copies and/or to amend your protected health and mental health information, unless it is stored data, which cannot be changed. There may be a fee for these services. You may also request an accounting of disclosures of your protected health and mental health information from this office.

We are legally obligated to maintain the privacy of your protected health and mental health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our private practices and apply revised privacy practices to protected health information.

You may register a complaint with office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Privacy Officer and/or the Practice Administrator to obtain answers to any questions you might have concerning this Notice. You may request a copy of this Notice.

Client's Name (printed): _____ Age: _____

Client's Signature: _____ Date: _____

If client is under 18 years of age:

_____ _____

Name of Client's Personal Representative Relationship to Client