PROFESSIONAL, PRIVACY & INFORMED CONSENT NOTICE

Mental Health Therapy and Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals.

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy. **Initials_____**

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed. **Initials_____**

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached. **Initials_____**

TREATMENT: When attending counseling sessions, there is usually an order to the process. During your first session with your therapist, you will be asked to discuss your current issues. You may also be asked questions regarding your family, current or past relationships, previous counseling, current and past medications, et cetera. The information you provider will be kept confidential, as mentioned previously. Gathering information about your past and present circumstances is necessary for planning and providing the best possible treatment. Depending on your given situation, you may receive a diagnosis. Again, this allows the therapist to create the most appropriate treatment plan. A multitude or treatment models exist in the counseling field. The most common ones used at ReCharge Counseling & Wellness are Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Solution Focused Therapy, Attachment Theory, Emotion Focused Therapy, Mindfulness and Relaxation and Person Centered. It may take time and several strategies to find the best method for you as an individual. Discussing your goals for treatment and requesting alternative strategies is an important part of your active participation in the counseling process.

LENGTH OF THERAPY: Therapy sessions are typically weekly for 50 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

CLIENT'S BILL OF RIGHTS

- Receive respectful treatment
- Refuse treatment or a particular intervention strategy
- Ask questions at any time
- Have full information about fees, method of payment, insurance reimbursement, etc.
- Choose your own lifestyle and to have that choice respected by your therapist.
- Have full information regarding counselor qualifications to practice, including licensure or registration, training, experience, etc.
- Inspect and receive a copy of any material to be disclosed to another individual or agency/organization

Therapeutic Relationship: During the time that you work with Ms. Davis, you will meet regularly for approximately 30/50 minutes per session. This is the time you will be billed for. Although our session may be very intimate psychologically, we have a professional relationship, not a social one, as a social relationship might lead to exploitation of clients and impair objectivity in the professional role. Ms. Davis' services will be rendered in a professional manner consistent with accepted legal and ethical standards. If you have problems with your counseling relationship, it is encouraged that you speak directly with your counselor. While benefits are expected from counseling, specific results are not guaranteed. As a client, you have the power to refuse or discuss modification of any of her counseling techniques or suggestions. Both the client and Ms. Davis have the right to withdraw from the therapy process. If the counseling process is withdrawn from, Ms. Davis will provide appropriate referrals upon the client's request. You may also file any grievances with the Texas State Department of Health and Human Services, and the contact information for them has been given in this document on page 1. Therapists are expected to provide services to clients only within the boundaries of their competence. They are also expected to acknowledge, be sensitive to, and respect the diversity of values, attitudes, opinions, and culture of clients and to avoid engaging in any behavior that is discriminatory, harassing, or demeaning to others. **Initials_____**

Fees: Fees are discussed before or during your first session. You are asked to pay at the time service is rendered. Ms. Davis accepts payments via Ivy Pay, a HIPPA compliant e-transfer service; or visa/mastercard. A request or invoice will be sent immediately after counseling services are rendered.

Cash Pay:

I agree to pay KaShunda Davis, M.S., LPC for counseling sessions at the rate of _____$95.00 per 50-minute (individual) or $145.00 per 60-minute (couple) teletherapy sessions. Initials_____

Insurance:

By using insurance, I am required to give a mental health disorder diagnosis that goes in your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during the session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding. **Initials_____**

IMPORTANT: Some psychiatric diagnoses are not eligible for reimbursement. In the event of non-coverage or denial of payment, you will be responsible to pay for services provided. **KaShunda Davis** of **ReCharge Counseling & Wellness PLLC** reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.
Initials_____

Insurance payment: I will give all insurance information required to the staff and request that they submit the charges to my insurance company for payment. I understand my insurance may not pay in full or may deny my services. I understand that I am financially responsible for all charges. This includes my deductible and/or co-pay. I authorize this clinic to furnish to my insurance company all information that may be required in order to process the claims for me and/or my dependents. **Initials_____**

ReCharge Counseling & Wellness currently accepts the following insurance. Please check if you will utilize insurance:

____Aetna:	Policy ID#_____	Group #_____
____Blue Cross Blue Shield:	Policy ID#_____	Group #_____
____Cigna:	Policy ID#_____	Group #_____
____Oscar Healthcare:	Policy ID#_____	Group #_____
____Oxford:	Policy ID#_____	Group #_____

Headway or ***Grow Therapy***, insurance billing companies will verify your insurance, copayments, limitations etc., prior to your first session.

ReCharge
Counseling & Wellness PLLC

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Cancellations: Teletherapy sessions are generally scheduled for 45-60 minutes. The appointment is reserved for you. Payment is expected for missed appointments and cancellations of less than 24-hour notice. If Ms. Davis is not available to take a call, you may leave a confidential ***voice mail*** at **214-836-3957** or ***email*** **rechargecounselingpllc@gmail.com**, which will be time stamped for delivery verification.

I agree to pay $45.00 for missed scheduled appointments if I do not give at least 24-hour notice by phone or email of my wish to cancel or reschedule. Please note, that insurance companies are not responsible for no-show fees. Initials_____

**Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events so that we may cancel or reschedule an appointment.

Emergency/Crisis Situations: Your counselor has voice mail at 214-836-3957, if you need to get in touch with her. Ms. Davis ***does not*** provide a 24-hour crisis counseling service. In case of emergency situations, your counselor will discuss appropriate emergency numbers, with you. **If in a life-threatening situation, *always* call 911 before contacting your counselor.** Please notify Ms. Davis if an "after hours emergency" has occurred so that a follow-up session may be scheduled if as soon as possible. **Initials_____**

EMERGENCY CONTACT:

It is necessary that **KaShunda Davis** of **ReCharge Counseling & Wellness** has someone to contact on your behalf. In case of an emergency who should we contact?

_____

Full Name Relationship Phone Number(s)

I agree to allow **ReCharge Counseling & Wellness** to contact my emergency contact on my behalf in the case of emergency **Initials_____**

Consent to Treat: I do hereby seek and consent to take part in the confidential treatment by KaShunda Davis, M.S., LPC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that after the final session or in the event that I have not attended a therapy session in three months that the client/therapist relationship will be considered closed unless I initiate further contact. **Initials_____**

*Your signature here indicates you have read, understand and accept this document (**Professional**, **Privacy** and **Informed Consent Policies**) and that any questions you had about this document were answered to your satisfaction, and that you were furnished a copy of this document. By your signature, you issue consent for KaShunda Davis, M.S., LPC to provide counseling, you understand your financial obligations and acknowledge your commitment to conform to these documents' specifications.

Printed Name(s) _____ _____

Client Signature _____Date_____

Client Signature _____Date_____

Therapist Signature _____Date _____

KaShunda Davis, M.S., LPC, License #80696

Informed Consent

Confidentiality: Your counseling relationship with KaShunda Davis is important and confidential. Information cannot be released regarding your counseling without your written consent unless disclosure is required by state law.

Exceptions to Confidentiality:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical records.
- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone or email.** Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text.
- **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk.

Part of providing quality care is respecting your privacy rights and maintaining confidentiality of all your records pertaining to therapy. KaShunda Davis, M.S., LPC will not use or disclose your health information for any purpose not described in this notice without your written authorization.

You may address grievances regarding the counseling process with the Texas State Licensing Board at Complaints Management and Investigative Section,P.O. Box 141369, Austin, Texas 78714-1369 or call 1-800- 942-5540.

At this time, counseling services are provided via HIPPA compliant video conferencing platform. An operating computer, smartphone or tablet with camera and microphone enabled are required for sessions, as well as quiet space in your home or other secure location prior to session beginning.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of Recharge Counseling & Wellness, PLLC

Signature of Client *Signature of Therapist*

Signature of Client

Date