



Therapeutic Consent and Client Contract

Please read the following policies carefully. If you have any questions or concerns, please discuss them with your therapist before signing below.

Notice of Privacy Practices

When one receives care for mental health and/or substance abuse, information related to that care might be more protected than other types of health information. Communications with a therapist in treatment are privileged and may not be disclosed without your written permission, except as required by law. The following are situations in which a mental health professional is required by law to reveal information obtained during therapy to other persons or agencies without the client's permission: (a) If a client threatens bodily harm or death to him/herself or to another person; (b) If a court of law issues a legitimate court order (signed by a judge), the practicing therapist will be required by law to provide the information specifically described in that order; (c) If a client reveals information relative to child abuse, child neglect, or elder abuse (past or present). Also, (a) If a client presents to therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; (b) If any sexual improprieties by a former therapist are reported, the therapist must report this to the state licensing board; (c) If any sexual improprieties by clergy are reported, the therapist must report this to the district attorney; (d) If a client is seeking reimbursement through an insurance company, it will be necessary to reveal confidential information to them; (e) Banks and credit card companies may be made aware that a person is receiving services from OBFT due to check or credit card processing; (f) If a client files a complaint or malpractice suit against a therapist, the therapist reserves the right to use his or her records to defend him or herself in court. A client's records may also be used to sue for delinquent payment.

Protection of client confidentiality is of utmost importance. At Olive Branch Family Therapy we uphold the highest standards for guarding your personal information. A client's personal, written consent is required should the need arise for one's information or records to be shared for any other reason than those required by law as stated above.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger physically, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel. Initial _____

Emergency Contact Name _____ **Telephone Number** _____

Informed consent for Telephone, Electronic, and Mail Contact

I understand communication through telephone, and other electronic means is not completely confidential to the extent that spyware and other dangerous hardware can gain access to protected material. I also understand text messages and emails will be kept in a password-protected account to which only my OBFT therapist has access. I trust my therapist will handle my private information respectfully and with care in order to protect my confidentiality. It is recommended that clients keep electronic communication brief and vague. Please do not write any information in an email which you would not want others to know. Email is best used for appointment-setting, initiating a phone call, or asking questions about Olive Branch Family Therapy and it's therapists. Initial _____

The Client-Therapist Relationship

The ethical code of marriage and family therapists prohibits dual relationships between clinician and patient. This means a therapist cannot engage with a client in any social occasion or through social media. Therapists and clients also may not be involved in any business activities other than



providing psychotherapeutic services. In order to further protect client confidentiality, the therapist will not acknowledge past or current clients in public unless the client first initiates the conversation. This prevents clients from being unwillingly put in a position to explain his or her relation to the therapist if asked by a nearby person.

Grievance Procedure

The Olive Branch Family Therapy therapists, Jill Davis M.MFT, LMFT and Beau Davis M.S., M.MFT, LMFT, and Aaron Norton, Ph.D., LMFT-Associate, AAMFT Approved Supervisor, Brittany Barksdale, LMFT, and Joshua Marshall LMFT are all licensed by the Texas Association of Marriage and Family Therapy. Should you need to file a formal, ethical complaint against a license holder, you may contact the Texas Department of State Health Services' Complaints Management Section at 1-800-942-5540.

Financial Agreement

You have the right to be informed of the cost of services rendered to you. Please read carefully:

- Payment of \$____ is due in full at the time of services. We require that you notify your therapist at least 24 hours in advance should you wish to cancel or reschedule an appointment.

Fees for Cancellations and Missed Sessions

- The fee for missed sessions or no-shows is the same as the full session fee of \$____.
- The fee for a late cancellation with less than 24 hours notice is \$50.
- However, canceling an appointment with less than 3 hours notice will be charged the regular full session fee.
- The penalty charges are not allowable charges to be applied toward insurance and are the sole responsibility of the client.
- Any phone call lasting over 25 minutes will be billed as a full therapy hour.
- Any document preparation will be billed at \$50 plus an additional hourly session fee beyond the first hour of the therapist's time.
- Other fees include a \$30 service fee for checks returned for non-sufficient funds. Before any future visits occur, the client or responsible party must pay the service charge plus the value of the check.

Minor patients: The parent or guardian accompanying the minor is responsible for full payment when services are rendered.

Olive Branch Family Therapy reserves the right to charge a client based on his or her individual need.
Initial _____

Fees Specifically Related to Legal Proceedings and Court Involvement

In the event a client requires his or her therapist's testimony or involvement in legal or court proceedings, client consent will be required. The therapist will be unable to disclose any information pertaining to other family members or parties in counseling without each person's specific consent. Court appearances, either requested or subpoenaed, as well as depositions and settlement conferences are billed at an hourly rate of \$150.00. These rates will be charged at a minimum of four hours which includes time spent on preparation, travel, waiting, and testimony. The initial minimum four-hour charge of \$600 is due at the time of the subpoena. These charges are not allowable charges for insurance and are the sole responsibility of the client. Because it is often difficult to accurately determine the time needed to appear in court, there is a need for the therapist to clear his or her appointment schedule for the entire day. Such scheduling makes it necessary to charge in this manner

Initial _____



Therapist Incapacitation/death

I acknowledge that, in the event the undersigned therapist become incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing a licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request or to deliver them to a therapist of my choice. Initial _____

Consent to Treat

I, the undersigned, request treatment from a licensed therapist at Olive Branch Family Therapy for outpatient mental health services and hereby authorize the clinical staff to administer such treatment as deemed necessary. I also certify no guarantee or assurance has been made as to the results or outcomes that may be obtained. Risks of treatment include potential for both emotional and relational discomfort related to issues discussed during the counseling process. I understand I am free to discontinue therapy at any time. I am aware this counseling office is not an emergency or 24 hour service. In the case of an emergency, clients are requested to call their primary care physician or 911. Initial _____

Signature

I certify the information which I have provided on this form is true and accurate. I have read and understand the above rights, authorizations, and responsibilities and have signed below to indicate my agreement with these terms. I have also read and understood the *Notice of Privacy Practices* and have signed below to indicate my agreement with its terms as well.

_____	_____
Client and/or Guardian's Signature	Date
_____	_____
Client	Date
_____	_____
Client	Date
_____	_____
Client	Date
_____	_____
Witness	Date



Limits on Confidentiality when Providing Therapy to Couples or Families

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

Initial _____

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