C A T H Y E I S E N H O W E R , L P C

4111 Medical Parkway, Suite 201, Austin, TX 78756 512.309.7405
info@cathyeisenhowerlpc.com cathyeisenhowerlpc.com

OFFICE POLICIES AND CONSENT TO TREATMENT

This form outlines my policies for providing psychotherapy services, your rights in this process, as well as relevant state and federal laws. You will receive a copy of this form once it's signed, and I will keep one as well. If you have any questions or concerns now or in the future about anything in this document, please ask and I will do my best to answer them. When you sign this document, it will represent an agreement between us regarding our professional relationship.

PSYCHOTHERAPY SERVICES: Psychotherapy is hard to describe because it works differently for each therapist and client (or client family). It depends on where you are in your life, what you bring into the room, and how committed you are to the process, which can take the form of something as simple as showing up for sessions. The work we do can be exhilarating, frustrating, scary, lonely, and joyful, among other feelings—all of the emotions that make us human. It's not always comfortable, and we are often asked to accept that discomfort as a zone in which we may deeply learn about ourselves in order to fuel change. There are no guarantees of what you (or your child) will experience, but therapy often helps clients have better relationships, solve their problems more easily, and experience less pain and distress.

The first few sessions will help me get to know why you have come to therapy and how we might be a suitable match to do this important work. At the end of that time, we can determine together if we think we are a good fit, and that includes my fit with your child in cases of child therapy. It's important that your child has some motivation to come to sessions for the therapy to be helpful. You'll have the opportunity to evaluate whether you, or you and your family, feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so it's good to be thoughtful about the therapist you select. If you decide we aren't a good fit, I will be happy to give you referrals to other qualified professionals.

SESSIONS: Sessions will be at least weekly and will be 50 or 55 minutes. The reason for this is that dosage in therapy is just as important as it is with medication, and, in my experience, less than once a week is not often enough to produce the changes that clients are seeking and simply creates frustration and disillusion. Once an appointment is scheduled, you will be expected to pay for it unless you cancel more than 48 hours before the appointment time (for Monday appointments that would be the Thursday before) or we can re-schedule the appointment before the next weekly appointment at a mutually agreeable time. You will have one grace cancellation after the 48-hour deadline. If you are using insurance, please note that insurance does not cover missed sessions, so you will be required to pay for non-rescheduled sessions out of pocket at the insurance rate.

CONFIDENTIALITY, ITS LIMITATIONS, & PROFESSIONAL RECORDS: I keep notes about our work together and copies of intake paperwork and other relevant documents in an electronic medical record system, compliant with state and federal regulations for privacy of personal health information. It contains information you have provided to me in writing as well as counseling notes of your (or your child's)

sessions. The record remains with me for a period of seven years following your last visit; at that time, it is destroyed. If at any time you wish to see your (or your child's) records, I recommend that we discuss it first and that if you decide to review them, that we do it together to minimize the likelihood of misinterpretation and distress sometimes experienced by untrained readers of professional records.

It is important that you understand that ***all identifying information*** about your treatment is kept confidential, even if I consult with another clinician to enhance your (or your child's) treatment. You will need to sign the **Authorization for Release of Information** before any information is provided to a third party outside my office, including for coordination of treatment with other health professionals or school personnel. Exceptions and/or limitations to confidentiality include the following:

- If there is an emergency situation in which I believe that you (or your child) may be a danger to yourself (or child's self), or that you (or your child) are gravely disabled.
- If you (or your child) communicate to me a serious threat of violence against someone.
- If I have reasonable suspicion that a child or an elder/dependent adult is being abused.
- If you file a complaint or lawsuit against me, I may need to disclose relevant information to defend myself.
- If a court or government agency requests information, I may be required to provide it.

If such situation arises, I will make every effort to discuss it with you before acting and will limit my disclosure to what is necessary.

EMERGENCY SITUATIONS: Generally, if you leave a voice mail with your contact information, I will return your call the same day, except on weekends and holidays. If I will be unavailable for an extended period, I will leave you the name and number of a clinician who provides coverage for those times. If you can't reach me and can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the clinician/psychologist/psychiatrist on call, call 911, or go to your nearest emergency room.

PAYMENT FOR SERVICES: You will be expected to pay the agreed-upon fee for each session at the end of each session (by cash or check) unless other arrangements have been made. Telephone conversations of less than ten minutes will not be billed. However, longer telephone conversations and time spent performing other services requested of me or that are necessary for the treatment will be pro-rated at the agreed-upon rate for psychotherapy services. Be sure to discuss with me any problems that arise during the treatment regarding your ability to make timely payments.

PATIENT/CLIENT RIGHTS: HIPAA provides you with many rights regarding your (or your child's) clinical records and disclosures of protected health information. These rights include requesting that I amend your (or your child's) clinical record; requesting restrictions on what information from your (or your child's) clinical records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and receiving a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

TERMINATION OF TREATMENT: You have the right to terminate your (or your child's) treatment at any time, as participation is voluntary. In such case, we will set a date for termination, review the progress achieved thus far, identify any remaining issues, and identify appropriate referrals sources. I may also terminate treatment if I believe that psychotherapy is contraindicated or if an issue emerges that is beyond the scope of my competence. Such concerns would be fully discussed with you prior to terminating treatment, and an appropriate referral would be provided, if applicable.

PROFESSIONAL LICENSURE: Cathy Eisenhower, LPC, is a Licensed Professional Counselor through the Texas State Board of Examiners of Professional Counselors. If during our time together you have any complaints, you may contact the Board at:
Address: Texas Dept. of State Health Services, MC-1982, 1100 West 49th St., Austin, Texas 78756-3183
E-mail: lpc@dshs.state.tx.us Website: http://www.dshs.state.tx.us/counselor
Telephone: (512) 834-6658 Fax: (512) 834-6677

CONSENT TO TREATMENT

I have read, understand, and agree to comply with the policies described above, and hereby consent to treatment. I agree to abide by the terms of this agreement and acknowledge that it is my responsibility to pay for services rendered by Cathy Eisenhower, LPC. I understand the limits to confidentiality and the office policies regarding fee payment and cancellations. I understand that this consent form covers me and/or my child while in treatment. In addition, I certify that I have been given copies of this document and the HIPAA Notice of Privacy Practices.

Client's Name (Print)	*Client's Signature*	Date

If client is a minor:

Parent/Caregiver's Name (Print)	*Parent/Caregiver's Signature*	Date

Parent/Caregiver's Name (Print)	*Parent/Caregiver's Signature*	Date