



## Client Agreement and Consent

**WELCOME TO WEAVINGS WELLNESS GROUP AND THANK YOU FOR CHOOSING TO USE OUR SERVICES.**

It is important for you to be informed about the nature of psychotherapy, the policies and procedures governing the help you will receive here, the fees charged for our services, and your rights as a client. At the end of statement there is a place for you to sign, indicating your general consent to therapy.

**PSYCHOTHERAPY:** “Counseling” and “psychotherapy” (therapy) are often used interchangeably to indicate forms of psychological help that address various kinds of personal and family distress (e.g. depression, anxiety, marital conflicts). The goals of therapy range from the relief of symptoms to significant life change as gains a better understanding of personal, interpersonal, and social circumstances.

The Weavings Wellness Group clinical staff is comprised of licensed professional counselors, licensed social workers, pastoral counselors and specialists with certifications in special areas of practice. Also on staff, are therapists in-training, working to obtain advanced degrees or to meet eligibility standards for licensure. All staff work within the standards and ethical guidelines of state licensing laws and professional associations. (A statement of Professional and Clinical Standards is available on request). Our therapists also respond to the spiritual and theological needs of clients who want these factors to be considered in their therapy.

**THERAPY PROCESS:** Therapy begins with an *intake process* to evaluate your needs and difficulties and to help you make a decision about engaging in therapy. Your therapist will work with you in determining the best course of treatment. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings (e.g., sadness, guilt, anger, frustration, helplessness). On the other hand, therapy has been shown to have many benefits (e.g., better relationships, solutions to specific problems, significant reductions in feelings of distress). There are no guarantees, however, of what you will experience. The therapy process is guided by a *treatment plan* designed jointly by you and your therapist. Therapy can take many forms, depending on the nature of your concerns as well as the personality and preferences of both you and your therapist. Progress in therapy depends on many factors, including regular attendance, talking openly with the therapist, motivation, effort, and life circumstances.

You and your therapist will decide together when your therapy is complete, but you may choose to withdraw at any time. If you decide to withdraw, it is recommended that you have at least one final appointment with your therapist rather than terminating by telephone, mail, or by not showing up. Periodically during therapy and at the time of termination, clients are given a Client Satisfaction Survey to assist the group in assessing the strengths and weaknesses of our services.

**THERAPY POLICIES AND PROCEDURES: Your Rights as a Client**

You have all of the rights established by the State of Texas governing clinical practices, such as:

- The rights of consent to treatment,
- Of seeking disclosure from your therapist about his or her qualifications,
- Of requesting a different therapist,
- Of ending treatment at any time,
- Of accessing the client grievance procedures,
- Of having your clinical record kept private (see “Confidentiality” below)
- Of having any tests, procedures, and recommendations explained to you in simple terms, and the right to refuse such tests, procedures, or recommendations.

**CONFIDENTIALITY:** What you tell your therapist will be kept confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, court order, or as part of the professional practice of this Group. For further information, please see our *Notice of Privacy Practices* and *General Consent for the Use and Disclosure of Protected Health Information*. Feel free to ask for clarification about anything you do not understand. Your privacy is very important to us, and we want to do everything possible to protect it.

**FEES AND PAYMENT:** The regular fee is \$120.00 for a 50-minute session for most counseling services and \$150.00 for the initial session. If you cannot afford the regular fee Weavings Wellness Group may adjust your fee, taking into account your income and number of family members. Proper documentation is required. Payment of your agreed upon fee is due at the time of your appointment unless prior arrangements have been made. You may pay by cash, check or credit card. A \$10 fee is charged on all returned checks. Please fill out the attached Client Financial Form-Section B, if you are using insurance or some other form of third-party payer.

**INSURANCE AND OTHER THIRD-PARTY PAYMENTS:** If you wish to use insurance or other third-party coverage (e.g., a managed care organization or employee assistance program) to pay for therapy, you are responsible for providing the Group with accurate and complete information. Weavings Wellness Group does not guarantee that your insurance or other coverage will pay your claim. You are responsible for the account balance and for deductibles and co-payments required by your insurance or third party payer. Please fill out the Client Financial Form Section-A, if you are going to use your insurance.

**INSURANCE AND CONFIDENTIALITY:** You should be aware that your contract with your health insurance company requires that Weavings Wellness Group provide the company with information relevant to the services you receive. At a minimum, we are required to provide a clinical diagnosis. Some companies require additional information such as treatment plans, summaries, or copies of your entire clinical record. We make every effort to release only the minimum information necessary for the purpose requested. This information will become a part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with your private information once it has been released to them.

**APPOINTMENTS AND CANCELLATIONS:** You will be charged for any appointment that you miss or cancel with less than 24 hours notice. Since this charge is not covered by insurance, you will owe the total of what your insurance would have paid plus your co-pay or deductible. If you do not use insurance your charge will equal your regular session fee. We prefer 48-hour notice of cancellation so that someone else may take that appointment time. We ask for a two-week notification of your plans to terminate treatment.

**LEGAL PROCEEDINGS:** The staff of Weavings Wellness Group **does not provide testimony in legal proceedings.** If you choose to subpoena your therapist or your records, however, you agree to pay for any required preparation time, for your therapist's time out of the office, and for travel at a charge equal to Weavings Wellness Group hourly rate.

**EMERGENCIES:** Weavings Wellness Group does not provide "emergency services". If you have an urgent concern, we try to schedule an appointment as soon as possible. If you have a critical emergency, contact one of the following: our number (512) 327-0020 which is answered by an answering service after the office is closed or the MHMR Hotline (512) 472-4357 or 911. After-hours messages can be left on the voice-mail system, but do not leave an urgent message since these messages may not be reviewed until the next business day.

**CONSUMER COMPLAINT HOTLINES:** Licensed Professional Counselors and Licensed Marriage and Family Therapists (800) 942-5540; Social Workers (800) 232-3162 or in Austin 719-3521; Licensed Psychologists (512) 305-7709; Pastoral Counselors (703) 385-6967.

## Weavings Wellness Group Agreement and Consent

In signing this, I acknowledge:

- I have read and understand the information in the Client Information, Agreement and Consent Form.
- I consent to treatment by Weavings Wellness Group.
- I voluntarily enter into therapy with the therapist whose name is listed below;
- I may withdraw from treatment at any time unless treatment is court ordered, and;
  - I am 18 years of age or over and have not been declared incompetent by a court of law, or;
  - I am the parent/legally-appointed guardian or other authorized representative of the client to be treated, if such client is 17 or younger, or;
  - Although under 18 years of age, I am legally empowered to consent to treatment per the conditions outlined in the Texas Family Code.
- I am financially responsible to Weavings Wellness Group as described in the Client Information, Agreement and Consent Form for services and treatment rendered to the client named in this consent.
- I understand therapy is a joint endeavor between the therapist and client, and specific results are not guaranteed.
- I will be informed if my therapist believes counseling is not appropriate for my circumstances or that I should be referred elsewhere.
- I understand that effective counseling involves my attending regularly scheduled counseling appointments and talking openly with my therapist.
- My therapist will inform me of any possible risks in my seeking therapy and will work with me in determining the best course of treatment.
- I understand my right to have any tests, procedures, and recommendations explained to me in simple terms, and I have the right to refuse such tests, procedures, or recommendations.
- I have been informed that my therapist \_\_\_\_\_ is a  
[ ] Staff Therapist [ ] Therapist in Training.

This form is an agreement between you, \_\_\_\_\_ and Weavings Wellness Group.  
When we refer to “you” below, it will mean your child, relative, or other person if you have written his/her name here: \_\_\_\_\_

I acknowledge that the information contained in the Client Information, Agreement and Consent Form has been made available to me, explained to me, or read by me and that it was presented in clear non-technical language. My signature affirms that the information is understood by me and enables me to make an informed voluntary consent to this treatment.

If client is a minor: I give permission for this minor child to receive therapy and for this minor child to receive therapy without a parent or guardian present.

Print Client’s Name: \_\_\_\_\_

Signature of Client, Parent, Guardian or Representative	Date
_____	_____

Authority to Represent Client	_____
_____	_____

Therapist	_____
_____	_____