Karen Sullivan, LCSW

INFORMED CONSENT AND THERAPY AGREEMENT

Client's Name _____ **Date of Birth** _____

Thank you for the privilege of working with you and/or your family. Please read below for information about our professional relationship. Your signature at the end of the form indicates your understanding of and agreement to the information and policies listed below.

Background and Therapeutic Interventions

I am licensed as a Licensed Clinical Social Worker, and I generally approach therapy from an integrative theoretical orientation, which means that I endeavor to choose theoretical approaches suited to the particular presenting issues and concerns of the client. Overall, I utilize a developmentally sensitive, neurobiology-informed approach to clinical problem solving. I use a variety of modalities, including Play Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Trauma-Focused CBT, Family Systems, and CBT. I view psychotherapy as a collaborative task, in which you take an active role in working toward your goals, both within and between sessions.

Risks and Benefits of Therapy

There are risks and benefits to participating in therapy that should be carefully considered. Potential risks include, but are not limited to:

- Uncomfortable levels of sadness, guilt, anxiety, anger, or other negative feelings
- Recall of and attention to unpleasant memories
- Thoughts and feelings that are disruptive to daily functioning
- Temporary worsening of symptoms
- Unsuccessful resolution of symptoms
- New and different symptoms may develop

While considering these risks, also know that the benefits of therapy have been well-documented through research. Some common benefits are decreased symptoms, improved communication in relationships, and better problem-solving and coping skills.

I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress. I will utilize my professional knowledge, skills, resources, and training to assist you. If you could benefit from a treatment I cannot provide, I will help you to obtain information and the appropriate referrals.

Initial Assessment

Our first session, and possibly the first few sessions, will involve an assessment of your therapy needs and goals. There are several possible outcomes of this initial assessment, as it is an opportunity for us to decide if working together may beneficial for you. If my therapeutic approach appears to fit with your individual goals, I will offer you some first impressions of what our work will include if you decide to continue with therapy and we will agree on a treatment plan.

Rights and Responsibilities

Your Rights:

- To be provided with professional care and respect
- To know your therapist's assessment and recommendations
- To refuse recommendations or treatment
- To ask about other treatments, their risks, and their benefits
- To obtain another professional's opinion at any time

Your Responsibilities:

- To be on time for appointments
- To be honest, open and willing to share your concerns
- To participate in the therapy process to the best of your ability
- To ask questions as needed
- To discuss any reservations about your treatment plan
- To report changes or events related to your problem

Limits on Confidentiality

Confidentiality is vitally important in creating a trusting and safe environment. Any information provided will be kept confidential and will generally not be shared without your written consent. Under certain circumstances, I may be required by professional ethical obligations, state or federal law to disclose confidential information without your written consent. Should disclosure be necessary, I will make reasonable efforts to inform you of the disclosure in a timely manner. Exceptions to confidentiality may include, but are not limited to:

- If I believe that you are a danger to yourself or to other persons, I may contact medical or law enforcement personnel.
- If you disclose information that leads me to suspect that a minor, elderly, or disabled person is being abused or neglected, I am required by law to notify authorities within 48 hours and I will comply with this requirement.
- If you file a lawsuit or a complaint against me for any reason related to your therapy, I am allowed to use confidential information to defend myself.
- If you waive the rights to privilege or give written authorization to disclose information, I will comply with your authorization.
- If I learn of previous sexual exploitation by a mental health provider I am required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider. The client has the right to remain anonymous when the report is filed.
- If a court order or other legal proceeding or statute requires disclosure of your information, I will obey the court order or the law.
- If the client is a minor, parents have access to records unless limited by a court order.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your written authorization. However, if your records are subpoenaed or if a judge issues a court order for your records, I am legally obligated to comply. In the case of a subpoena, I will contact you so you (and/or your attorneys) can take steps to contest the subpoena. If you do nothing to contest the subpoena after being notified by me, I will obey the subpoena.
- I may consult professional colleagues if needed to enhance the therapeutic services you receive; such consultations will be done without disclosure of your individually identifiable information.
- Information contained in communications via computers with limited security/control, such as unencrypted e-mail, and telephone conversations via cell phone, are not secure and can compromise your privacy.

Information that may be requested includes, but is not limited to: types of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

Most insurance companies require a clinical diagnosis to reimburse for treatment. Some may require additional clinical information to support payment. Information collected by an insurance company will become part of the company's files.

Initials: _____

Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. Medical data has been also reported to be legally accessed by enforcement and other agencies, which may place you in a vulnerable position. The safest way to protect confidentiality is to pay cash for treatment. If you elect to use your insurance coverage to pay for treatment, I will assume that you have evaluated the stated risks and elected to proceed.

By your signature below, you acknowledge that you have been advised of these limits to confidentiality and potential risks.

Parents and Minors

While privacy in therapy is crucial to successful progress, parental involvement is also essential. In order to balance both, I welcome any input from parents about concerns regarding children or teens. I will explain to children and teens that the following information will be shared with their parents:

- Treatment plan, goals, and progress toward goals
- Any disclosure of abuse or neglect
- Any plan to cause harm or death to themselves or any other individual
- Risky behavior that could result in serious harm

If you are a parent or guardian who is consenting to treatment for a minor, by signing this Agreement, you affirm that:

- you are the parent or legal guardian of the child;
- you have the legal right to consent to psychological treatment for the child;
- there has not been a Divorce Decree or any other Court Order that limits your ability to consent to the child's treatment.

If the child's parents are separated, divorced or never married, it is my practice to require BOTH parents to consent to treatment, in compliance with any Divorce Decree or Court Order that may be in place. I will also require a copy of the Divorce Decree or Court Order prior to providing any services to the child, and by your signature below, you agree to provide it immediately upon request.

In my practice, if the parents of the child client have remarried or have significant others who may be involved in the child's therapy, I like to meet with all the adults before seeing the child to obtain signed Authorizations for the limited sharing of information regarding the child, and to establish the boundaries for my treatment of the child. My first rule is that none of the adults should ask to speak with me before the child's appointment in front of the child. If you have information to share, please do it privately. Also, I do not allow step-parents to make therapy appointments for child clients unless the child's parents have signed an Authorization allowing the step-parent to schedule the child's appointments.

Social Media

You are entering into a professional, not a social, relationship with me. Please understand that your confidentiality and privacy is my priority. For this reason, I do not accept friend or contact requests from any current or former clients on any social media sites. You are welcome to view my professional Facebook page to read and share any professional articles that are posted. You may find my practice on internet sites that encourage you to rate and review my services. Please know that I have not and will never request current or former clients to rate or review my services as this jeopardizes your confidentiality and privacy. You, of course, have the right to express yourself, but I urge you to take your privacy as seriously as I take my commitment of confidentiality to you.

Records

Documentation of sessions consists of a summary of each meeting and may include general issues addressed, possible symptom presentation or change, level of functioning, mental status, diagnosis and treatment plans. Federal and Texas law requires that I maintain appropriate treatment records for at least 6 years from the last date of service. If the client is a minor child, I must maintain treatment records for 6 years from the date the child turns 18.

As a client, you have the right to obtain a copy of your records upon submission of a written authorization. The records of your treatment will contain confidential information about you. Texas law requires that all requests to review or obtain copies of your records must be made in writing. In my practice, I require that clients sign an appropriate authorization before I release any records to them.

I have determined that a reasonable, cost-based charge for providing you with a copy of your records will be $25.00 for the first 20 pages and $ .50 cents per page thereafter, plus actual costs of shipping or mailing. Generally, I am not required to provide copies of requested records until the fee is paid.

Payment

You agree to pay my professional fee of $130 for a 45-50 minute individual session or $150 for a 45-50 minute family session. In addition to individual or family sessions, it is my practice to charge $130 per hour on a prorated basis for other professional services that you may require such as report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings or consultations which you have requested, or the time to perform any other service which you may request of me.

Payment is due at the time the service is rendered. I will provide a monthly receipt which you may choose to submit for out of network benefits with your insurance company. Cash, check, Visa, MasterCard, American Express and Discover are accepted. There is a $35 service charge for any returned checks.

Litigation Policies and Fees for Court-Related Services

- **I do not enjoy going to court and I do not want to deal with the negative feelings that can result from court or deposition testimony**.
- The nature of the therapeutic process often involves making a full disclosure with regard to many matters which may be extremely private, upsetting or embarrassing. If you become involved in any legal proceeding during your therapy with me, including but not limited to divorce and custody disputes, or personal injury lawsuits, you understand that this could result in the disclosure of information that would otherwise be confidential. By your signature below, you acknowledge my position and agree to abide by my litigation policy.
- If you involve me in your litigation, or if you or your attorneys subpoena me to provide my records, testify in court or give a deposition, I will comply with a lawfully issued subpoena.
- **My hourly charge for all time related to court cases or litigation is $300.00 per hour. You also agree by your signature below to execute and sign a Credit Card Authorization and provide a valid credit card to ensure payment for the time I must spend dealing with your litigation.**
- If I am subpoenaed to provide records or testimony, you also acknowledge and agree that you will pay for all of my professional time, including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, time spent testifying in court or deposition, and time spent consulting with the attorneys **regardless of which party issues the subpoena or requires me to testify**.
- If I am required to appear at any legal proceeding, testify in court or give a deposition in Fort Bend County, I will charge a retainer of $1,200.00 (for a minimum of 4 hours at $300.00 per hour), which includes preparation time, travel time (door-to-door), and attendance at any legal proceeding.
- If I am required to testify in court or give a deposition outside of Fort Bend County, I will charge a retainer of $1,800.00 (for a minimum of 6 hours at $300.00 per hour). If the actual time spent is less than the retainer, I will refund the overage within five (5) business days.
- If the attendance at a legal proceeding, court or testimony in a deposition exceeds 4 hours (in Fort Bend County) or 6 hours (outside Fort Bend County), all additional time will be billed at $300.00 per hour and you will be invoiced for the amount due. Payment is expected upon receipt, and I will run that charge against the credit card on file unless you have notified me in writing that you prefer to pay with cash, money order or a cashier's check.
- When I go to court or give a deposition, I have to clear my schedule and not see other clients, so there is a 48-hour cancellation policy for court and depositions. For example, if the court appearance or deposition is scheduled for Monday, this office must be notified of any cancellation no later than 8:30 am on the Thursday before. Any cancellations that occur within the 48-hour time frame of the court appearance or deposition are **NON-REFUNDABLE**.
- I will accept cash, money order, cashier's check, or credit cards for payment of time related to court appearances or deposition. **NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES**. All payments are due 48 hours prior to the scheduled court appearance or deposition, and no later than 8:30 am on Thursday if the court hearing/deposition is scheduled for a Monday. By your signature below, you expressly authorize me to run these charges to the credit card on file in our office unless you notify me that you intend to make payment by cash, money order or cashier's check.

- Finally, if I am subpoenaed by one party to provide records or testimony, I reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers.

I will not perform social studies or custody evaluations. I will not provide recommendations regarding possession, custody, access to or visitation with minor children. I will not provide evaluations or paperwork for FMLA or for short/long disability applications. I will not provide medication or medical advice. I will not provide legal advice. These services are NOT within the scope of my practice.

Missed Appointments

Consistency and communication are essential for therapeutic progress to occur. By signing this form, you understand that a full session fee will be charged for any missed appointments in which you have not provided 24 hours' notice of cancellation. You may cancel appointments by calling, texting, leaving a voice mail message, or sending an email.

Termination of Treatment

The length of treatment varies depending on the treatment goals and the client's personal situation. Progress toward treatment goals will be discussed with you during the course of treatment. I intend to terminate treatment when the therapeutic needs are met, to the maximum possible extent. You also acknowledge that there is no guarantee of a cure.

You may choose to terminate treatment at any time. I do hope that you will discuss any concerns with me prior to making this decision. I will respect your wishes to terminate. You understand that the method you choose to accomplish termination will impact any decision to resume a therapeutic relationship in the future.

Contact Information

Karen Sullivan, LCSW

Registered Play Therapist-Supervisor

(713) 826-3783

therapy@karensullivanlcsw.com

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unable to secure confidentiality. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you are unable to keep yourself safe, contact any of the agencies listed below. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice.

Additional resources for general use or in the event of after hours crisis or suicidal thoughts:

Emergency	911 or nearest hospital
Crisis Hotline	(713) 228-1505
Children's Protective Services	(800) 252-5400
MHMRA of Harris County	(713) 970-7000
Texana MHMR of Fort Bend County	(800) 633-5686

Interactions outside the Office

If we happen to encounter each other outside of the professional setting I will not address you unless you address me first. This is also for the protection of your privacy from those either of us may be with. I'm happy to return a friendly greeting but will allow you to take the initiative if you would prefer to do so.

Electronic Communications:

- **E-mail is an important tool for communication, but requires extra care**. E-mails should only be sent to me via the secure e-mail program I have selected for my practice. At the beginning of our relationship, you will be given instructions for sending secure e-mails. If you choose not to respect my policy regarding e-mail communications, I reserve the right to terminate therapy and refer you to other providers. Any e-mails you send to me will be printed and will become part of your clinical record.

- **Text messaging is for scheduling matters only.** I do not conduct therapy via text. If you need to share information regarding a clinical matter, please use my secure e-mail instead of texting me. If you choose not to respect my policy regarding text messages, I reserve the right to terminate therapy and refer you to other providers. Any text messages you send to me will be printed and will become part of your clinical record.

- **I do not allow audiotaping of sessions unless we have agreed otherwise in advance and you have signed a specific written authorization for the taping to occur**. For this reason, I request that you turn your phone off when you enter my office. I reserve the right to confirm that your telephone is off, or request that you leave your telephone in your car. If you refuse to confirm your phone is off, or if you refuse to leave your phone in your car when requested to do so, I will cancel the session. We can then discuss whether to reschedule the session or terminate our therapeutic relationship. If the decision is to terminate, I will confirm the termination in writing and include referrals to other providers.

By your signature below, you acknowledge that you understand my policy on the audio taping of sessions and you agree to abide by it.

Plan for Practice in case of Death or Disability

In the event of my death, incapacity or disability, I have made arrangements for another psychotherapist to take over my practice, assume control of my records, meet with clients, make appropriate referrals to other providers, if necessary, and take all reasonable steps to manage the practice for the benefit of my clients. By your signature below, you authorize my designee to contact you directly, and use and disclose your confidential mental health information and records for the stated purposes.

Complaints

You have a right to have your complaints heard and resolved in a timely manner. If we cannot work things out to your satisfaction you may inform your insurance carrier and file a complaint with them or with my licensing board.

- Complaints to my licensing board may be sent to the Texas State Board of Social Worker Examiners of Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369, telephone 1-800-942-5540.
- If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

Agreement:

I understand the nature of the proposed therapeutic treatment and I give my informed consent for psychotherapeutic treatment by Karen Sullivan, LCSW.

I have read the above Agreement carefully, I understand the terms of this Agreement and I agree to comply with them.

Initials: _____

If the client is a child:
I understand that Karen Sullivan, LCSW will require a copy of the pertinent Divorce Decree or Court Order if the requested counseling is to involve a minor child whose parents are parties to a Suit Affecting the Parent Child Relationship in order to make sure that the parent bringing the child to therapy has the legal right to do so. I agree to provide the requested document(s) before Ms. Sullivan provides any services to the child. I understand that if I fail to provide Ms. Sullivan with these documents, she will refuse to see or provide services to the child. By my signature below, I acknowledge and agree that I am the parent, legal guardian or Managing Conservator for the minor child listed above; and I give my informed consent for Karen Sullivan, LCSW to provide counseling services to that child.

I have also been informed regarding fees related to legal proceedings and Ms. Sullivan's litigation policy. I agree to abide by that litigation policy. If I choose to involve Ms. Sullivan in my legal proceeding, I agree to pay the fees set forth in this agreement, and I further agree not to contest any of those fees that are charged to my credit card on file.

I understand that this Agreement is a contract between me and Karen Sullivan, LCSW, and may be legally enforced as a written contract. I agree that this Agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated AFTER the date of this Agreement and must be provided to Karen Sullivan, LCSW. I agree that a copy of this Agreement has the same force and effect as the original.

_____	_____	_____
Client signature	Printed Name	Date
_____	_____	_____
Parent signature	Printed Name	Date
_____	_____	_____
Parent signature	Printed Name	Date