Parenting Center

Client Name ___________________________________

Confidentiality and Fee Acknowledgement

The counseling program at The Parenting Center is designed to help people with personal or family problems. It is our goal to decrease emotional distress so that clients can achieve a more positive level of functioning and experience a greater sense of well-being. The Parenting Center attempts to do this through play therapy, individual, family, couple and group counseling in the shortest amount of time possible. The therapist may recommend the client attend an education class in combination with counseling or make referrals for additional services at The Parenting Center or other agencies.

<u>Confidentiality</u>

I understand that the information disclosed in counseling is confidential. However, my counselor may discuss my case with his/her supervisor for consultation. Only the counselor and select staff have access to my file. Information will not be released to any other source without my written consent. I understand that the exceptions to confidentiality occur when:

1) There is suspicion or disclosure of possible abuse of a child, elderly person, or disabled person.
2) There is a probability of imminent physical injury to self or others.
3) The client is a child and a parent, guardian or managing/possessory conservator has a right to the information.
4) A judge orders the release of records.
5) Insurance, managed care companies, individuals, corporations, or governmental agencies involved in paying or collecting fees for mental health services require information for processing payment or collection.
6) When a chronological narrative summary is requested.
7) An allegation of negligence is made by a client regarding a therapist.

<u>Financial Agreement:</u>

I have been informed that I will pay a fee of $ ____________ for each 50 minute counseling session. *(A fee of $100 is the average fee for a 50-minute counseling session in the DFW metroplex.)*

I understand I will be charged my normal fee or $25.00 (whichever is greater) for any appointments I do not cancel at least 24 hours in advance.

I understand in order to cancel my appointment; I must call 817-332-6348 and leave a message.

I understand I will be charged for the therapist's time spent in court or in consultation at the rate of $100 per hour with a $400.00 minimum retainer.

I understand I will be charged $50.00 for sessions denied by Medicaid, CHIP, Child Protective Services, or other third-party payer and agree to pay in full.

I understand that if I request a copy of my records, a minimum fee of $25 will be charged.

I understand that if I have any grievance regarding my counseling I should contact the Director of Clinical Services at The Parenting Center.

I also authorize my therapist to contact medical or law enforcement personnel if the therapist reasonably suspects I may do serious harm to another or myself.

I understand if I have a mental health emergency after normal working hours I will follow the directions indicated on The Parenting Center answering machine or call 911.

I understand that I will receive a copy of this form if I request one.

Termination of Services

I understand that if I fail to come for my appointments on a consistent basis my counseling services will be terminated by the therapist.

I understand that if I fail to show for two consecutive appointments, my time slot will no longer be reserved and I must call the scheduling office for a new appointment.

______________________________________	______________________________
Client / Parent / Guardian Signature	Date
______________________________________	______________________________
The Parenting Center Representative	Date

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