CRESTVIEW
Psychological Testing & Counseling Center

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CRESTVIEW PSYCHOLOGICAL TESTING & COUNSELING CENTER
DISCLOSURE AND INFORMED WRITTEN CONSENT FOR TREATMENT

INFORMATION AND AGREEMENT
Thank you for choosing me to be your therapist. I am prepared to provide professional counseling services for you and I will attempt to provide you the best I have to offer; however, I cannot guarantee you a specific result. I will meet with you only as long as I believe my professional services are beneficial to you. If necessary, I will refer you to another professional. You may reach me at my office at (479) 316-0145. I will most likely be in session and you may leave a private voicemail. I will endeavor to return calls the same day but I may not be able to do so each time. If you are in a severe, life threatening crisis, you should contact the Needs Assessment Office at Springwoods Behavioral Health in Fayetteville at (479) 973-6000 or the Crisis Intervention Hotline at 1-888-274-7472.

Some of the therapy techniques I use include history and information gathering by interview and assessment inventories. I will explore thinking, acting and feeling aspects of your life and situation. If appropriate, I may request to meet with the entire family or various subsets of the family. Affirmation, confrontation, teaching and homework assignments are all aspects of my style. I will continually assist you in finding solutions that address the reason you came for treatment. If I believe that medication is needed, I will refer you to a medical doctor for an evaluation. If you have any concerns or complaints about licensed mental health practitioners, you can contact the Arkansas Board of Examiners in Counseling, 101 E Capitol Ave Ste 202, Littlerock, Arkansas72201 or by calling (501) 683-5800.

PAYMENT POLICY
My policy is for each person receiving professional treatment to pay at the time the services are rendered. Any other arrangements must be made in advance. A $20 administrative fee will be charged on all checks returned for non-sufficient funds.

My fees are based on 53-minute sessions and the per-session fee is $150.00

In the event that you need my testimony in any legal proceedings, regardless of what an attorney or Judge subpoenas me, there will be a $300 charge per hour.
Initial: _____

CANCELLATION/MISSED APPOINTMENTS
I understand that it may, at times, be necessary to cancel an appointment. To help me be most efficient and responsible in the use of my time, I require that **any changes or cancellations be made at least 24 hours in advance, Monday through Friday.** If there's a need to cancel a Monday appointment, that cancellation would need to be made **by the Friday before the appointment**. **Any changes or cancellations received less than 24 hours in advance will be charged a $75 cancellation fee on the first occurance and $150 on any occurance thereafter. Any missed appointments with no call received will be charged to your account.** Most insurance companies do not cover missed appointment charges.

INSURANCE
Many insurance policies provide partial to total coverage for mental health services. Your insurance is a contract between you and your insurance company It is not an agreement between the insurer and me. This means that your fees for psychotherapy are your responsibility regardless of insurance coverage that may exist.

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CONFIDENTIALITY

All our sessions are confidential. I will use my professional discretion in disclosing communications related to parent-child and adolescent issues. You can expect me to honor the confidentiality of the child or adolescent, and also inform the parent, if I believe a serious or life-threatening situation exists. I will keep confidential anything you say to me with the following exceptions: (1) You direct me to tell someone else and give me written consent to do so. (2) I determine you are a danger to yourself or others. (3) There is a strong suspicion of child abuse or neglect (I am mandated by law, Act #1208 to report this) or the abuse of the elderly or handicapped. (4)1 am ordered by a judge in a court of law to do so.

SOCIAL MEDIA

Friending- I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

RECORDS

Your counseling records will be kept at the clinic for a minimum of seven years. These records will contain all the paperwork you have submitted, progress notes and any evaluation measures that I have used. It is my responsibility to safeguard and protect information in those records. The records are the property of Crestview Psychological Testing & Counseling Center. If there is a situation where you need information to be given to another professional, you will need to sign a consent form (provided by the professional) for that to be done. If there's a custody situation, I must protect the interests of the child and will not release information or records unless in a court of law, upon the orders of that court.

ELECTRONIC COMMUNICATION

I frequently communicate with clients via cellular phone. This includes calls, texts and email. Please understand that your confidentiality is always compromised when communicating by electronic devices or mail. There is always the risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with your psychotherapist constitutes implied consent for reciprocal use of electronic and mail communication. Please circle whether you authorize contact by cellular phone via calls and/or texts and email.

YES / NO Initial: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorized treatment of the person named below and agree to pay all fees for such treatment. I agree to pay all charges for me and members of my family shown by statement, promptly upon presentment thereof, unless credit arrangements or insurance arrangements are agreed-upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date.

In order to keep costs as reasonable as possible, I require payment at time of service. Payment will be received at the beginning of your session with the therapist. Accounts with no financial activity for 60 days may be sent to a collection agency.

I attest that I have read this information sheet and I am aware of my therapist's degrees and credentials. I also understand the conditions as stated above and I agree to receive treatment under these conditions.

_____ _____

Client / Parent signature Date

_____ _____

Therapist signature Date