Soul Purpose Counseling

Courtney Ajiodo, M.A., LPC, LCDC

Information and Consent for Therapy

Name of Client: _____

Consent to Treatment:
I hereby voluntarily consent to evaluation, recommendation and/or treatment by Courtney Ajiodo, MA, LPC, LCDC. I am aware that the practice of psychotherapy/counseling is not an exact science. As a consequence, I acknowledge that no guarantee has been made to me concerning the result of any evaluation or treatment that may be rendered. Further, I understand that evaluation and treatment will involve discussion of personal events in my own history which, at times, can be uncomfortable and is at all times very personal.

Limitations on Confidentiality:
The law protects the privacy of all communications between a client and a mental health provider. In most situations, the provider can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by law. Your signature below provides consent for those releases of information, as follows:

A. Situations required by state law: Instances of actual or suspected child or elder abuse, abuse of the infirm, or neglect, must be reported to the Protective Services Division of the Department of Human Services. In cases of abuse that have already been reported, I may request a copy of the case dispensation from the caseworker.
B. Psychiatric or medical emergencies: If I believe someone is in imminent danger of suicide or homicide, I am required to and will take protective actions. This may include notifying the appropriate medical or law enforcement personnel and/or seeking hospitalization for the client.
C. Court orders: If a court order, other legal proceedings, or statute requires disclosure.
D. If you are filing a complaint or are a plaintiff in a lawsuit. Where you bring up the question of your mental health, you will have already automatically waived your right to the confidentiality of your records in the context of the complaint or lawsuit. You may discuss with your attorney obtaining a protective order to help maintain confidentiality of your records.
E. Sexual exploitation by a health care provider: If you have been sexually abused or exploited by a physician, therapist, spiritual counselor, or other health care provider, I must report this to the appropriate licensing agency and the District Attorney.
F. When you sign a release of information regarding your records: This directs me to share that information with another party.
G. Nonpayment for services: This would require that I give your name to a collection agency to seek payment for monies due.

Maintaining Professional Service:
In the interest of continued professional development and integrity of treatment, I engage in supervision and consultation as I see the need to do so. If I need to seek consultation or supervision regarding your treatment, I will change identifying details to protect the confidentiality of your identity.

Appointments:
Individual therapy sessions are generally scheduled once weekly and last 50 minutes. The success of our work together depends on both your presence and your promptness. Because your session time is reserved for you, I charge for missed appointments if not given 24 hours notice of cancellation.

Professional Fees:
The responsibility for payment of professional services is yours. Your individual session price will be $__95__ per 50 minute session. I charge this amount for any professional services you may need.

Billing and Payments:
I request payment at the time a session is held, unless we agree otherwise. In the event of financial hardship, I may be willing to negotiate a temporary fee adjustment or an installment payment plan. I accept credit cards, cash, and checks in payment of fees. I generally do not schedule an appointment after the third session in which payment is not received unless you have worked out another arrangement with me in advance. This policy keeps my practice financially sound and avoids your incurring additional financial obligations and debt.

Insurance Reimbursement:
It is important to review and evaluate resources you have available to pay for your treatment. Health insurance often provides some coverage for mental health treatment, and if you request I will provide you with a form you can file with your insurance company for reimbursement; however, you are responsible for full payment of my fees. I suggest that you review the section of your insurance information or coverage booklet that describes mental health services so that you will be informed of your insurance plan's rules with respect to deductibles, co-payments, limitations on coverage, and what conditions and therapies are covered by your plan. You should be aware that any information provided to you for purposes of filing for insurance reimbursement will become part of the insurance company's files and probably stored electronically, and I will have no control over what the insurance company does with the information. Your signature acknowledges that you have consented to the disclosure of your confidential information in that context.

Ending Therapy:
Either the client or the therapist has the right to stop ongoing therapy. Usually therapy ends by mutual agreement when client's goals have been adequately reached and symptoms adequately addressed. If I believe that our therapeutic work is not helpful or is harmful to you, I will speak to you about ending therapy and/or referring you to another therapist. If you ever feel that our work is not helpful, I urge you to speak to me directly about your concerns. If you discontinue coming without notice of your intention to end therapy, I will close your file thirty (30) days after our last session. This would mean that I would not be available to assist in a crisis or to provide ongoing sessions. If you would like to re-enter therapy with me after your file is closed, treatment can resume after we meet to discuss your reasons for discontinuing, if I have an opening in my schedule at that time.

Emergencies:
I do not provide 24-hour emergency coverage. However, if you are an active client you may reach me in case of an emergency by calling 832-527-9435. I will return your call as soon as I am available to do so. However, if in an emergency you are not able to reach me quickly enough, you may call Crisis Intervention of Houston at 713-HOTLINE or the The Harris Center of Mental Health and IDD Hotline at 866-970-4770. If your situation is life threatening, you should call 911, your primary care physician, or go to the nearest emergency room.

Consent to Use of Technology:
HIPAA regulations and my professional Code of Ethics both require that I keep your Protected Health Information private and secure, and this is my intention. Email and/or text are convenient ways to handle administrative issues such as scheduling or receipt requests, but email is not fully secure. Potential use of using electronic communication include misdelivery to an incorrect address, "hacking" of emails by a third party, and retention of emails on servers maintained by email providers such as Gmail, Comcast, etc., where it could be accessible to employees, among other risks. For these reasons I do not use email to discuss substantive clinical issues. By your signature below you give permission to use these forms of communication in the course of your treatment as described above. If you are not comfortable with these risks or do not wish to give this consent, please inform me of that and we will handle administrative issues by telephone.

Notice Regarding Complaints:
Complaints regarding services by Licensed Professional Counselors can be directed to: Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information.

Except in the case of gross negligence or malpractice, I or my representative(s) agree to full release and hold harmless Courtney Ajiodo, LPC, LCDC from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

Your signature below indicates that you have read and understand the information in this document and that you give informed consent to its terms.

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist or Witness Date