INFORMED CONSENT FORM

QUALIFICATIONS

My name is Michelle Ezell; I earned a Master's degree in Family Sciences and currently a Licensed Marriage and Family Therapist Associate with the Texas State Board of Examiners of Marriage and Family Therapists, Mail Code 1982, P.O. Box 149347, Austin, TX, 78714. The telephone number for the board office is: 512-834-6657. Should you feel the need to file a complaint with either board you may call one of the numbers above or do so in writing at one of the addresses.

CLIENT/THERAPIST RELATIONSHIP

You and I have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor are any sort of trade of service for service.

RISKS AND BENEFITS

Counseling is beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues that may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING

Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is my intent to convey the policies and procedures used in our practice, and I will be pleased to discuss any questions or concerns you may have. I provide short-term counseling designed to address many of the issues clients are dealing with. Your first visit will be an assessment session in which you and I will determine your concerns, and if we both agree that I can meet your therapeutic needs, develop a plan of treatment.

The goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and I are not a good fit, please discuss this matter with me to determine if transferring to a more suitable therapist is right for you. If you and/or I decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

APPOINTMENTS

During our first session, I will need to collect basic information, and we will usually meet for a 55-minute session. We can schedule meetings for both your and my convenience. I will tell you at least one week in advance of my availability or any other times we cannot meet. If you are bringing your child in for counseling please note that children may not under any circumstances be left in the office without a parent or legal guardian. If this occurs, I will make a call to report the incident to Child Protective Services.

An appointment is a commitment to our work. We agree to meet here and to be on time. If you arrive late for an appointment, the session will still end at the regularly scheduled time. Being late for an appointment by 20 minutes or more will require that you reschedule. If I am ever unable to start on time, I ask your understanding. I also assure you that you will receive the full time agreed to. On rare occasions there may be a crisis that I am handling right before your session and I will not be able to begin on time. If this occurs, then the session will end after a full 60 minutes, and I thank you for your patience when/if this occurs.

CANCELLATIONS/NO SHOWS

A cancelled appointment delays our work. I will consider our meetings very important and ask you to do the same. If you must cancel or reschedule your appointment, I ask that you call me at 682-710-2809 at least 48 hours in advance. You may leave a confidential voicemail at anytime of the day at 682-710-2809; however, please be informed that it may take up to 24 hours to return your call. On the rare occasion, I may not be able to return your phone call for 48 hours. Additionally, I may not return phone calls on some evenings or weekends.

Regular attendance at your counseling session is one of the keys to a successful outcome in counseling. Your session time is reserved for you, and I will do my best to fill a canceled session. A late cancellation is considered not cancelling your appointment within 48 hours. A no-show is defined as not showing up for your appointment. If you no show a session, you will not be automatically placed in that date/time for the next week. Please call as soon as possible after the missed/no-show session to schedule your next appointment. The late cancellation/no-show fee will be a regular session fee of $40.00, and this must be paid before a new session is scheduled. It is important to note, that some insurance companies do not allow for a therapist to directly bill clients under for late cancellations/no show, and they also do not themselves pay for late cancellations/no show fees. Two late cancellations or two no show appointments will result in me providing you a referral to another therapist. These late cancellations/no-show appointments do not have to occur in consecutive weeks. If you are a DARS client, late cancellations/no-show appointments will be reported to the Department of Assistive and Rehabilitation Services (DARS).

PAYMENT/INSURANCE FILING

Payment of fees is expected at the time of each appointment. Your fee will be $55.00 per session, and I request that payment be made by card before your session begins.

EMERGENCIES – 24-HOUR COVERAGE

You may encounter a personal emergency after normal business hours, which may require prompt attention. Please call 911 or contact one of the numbers below for assistance:

- Crisis Link (24 HOUR HOTLINE) 800-784-2433 (1-800-SUICIDE)
- Dallas Suicide Hotlines 214-828-1000 or 866-672-5100

- Arlington Memorial Hospital 817-548-6100
- Medical Center of Arlington 817-465-3241 817-467-7486 (metro)
- Millwood Psychiatric Hospital 817-261-3121 (24 hour emergency services)
- John Peter Smith Hospital 817-927-1088 (24 hour emergency services)
- Parkland Memorial Hospital 214-590-8761 (24 hour psychiatric emergency services)

CONFIDENTIALITY

Effective counseling is best accomplished in an atmosphere of trust and freedom of expression and disclosure. I will take every reasonable measure to ensure your confidentiality. However, confidentiality and privileged communication is limited under Texas law and professional codes of ethics. I am required to report any suspicions or evidence of child abuse; abuse of those who are elderly or disabled; a person's intent to take harmful, dangerous, or criminal action against another human being or against himself or herself, and other limitations outlined under the law and professional codes of ethics. Additionally, to assist in being able to maintain your privacy and confidentiality, I will not communicate with you via unsecure electronic methods (i.e., e-mail, text messages, etc….).

TREATMENT OF MINORS

Parents and legal guardians have the right to request information concerning a minor's evaluation and treatment. I will protect the rights and confidentiality of all minors and use my discretion in communicating information disclosed by minors in private. Risky behaviors such as drug use, running away or self-harm will be reported to parents/legal guardians. We will further discuss the issue of confidentiality of minors prior to beginning services.

EMERGENCY CONTACT

In the case of an emergency or if I become concerned about your safety or the safety of those around you, I may need to contact someone close to you (relative, spouse or close friend). Please write down the name and contact information of your chosen emergency contact:

Name:_____ Phone:_____ Relationship:_____

ATTENDANCE IN COURT

A session fee of $250/hour will be charged in the event that Michelle Ezell is requested to attend court for any reason. This may be in the office or over the telephone, and payment is due at the time of the communication.

Additionally the below schedule of fees may be charged according to the descriptions:

1. Preparation time (including submission of records): $220/hour
2. Phone calls: $220/hour
3. Depositions: $250/hour
4. Time required in giving testimony: $250/hour
5. Mileage: $0.40/mile
6. Time away from office due to depositions or testimony: $220/hour
7. All attorney fees and costs incurred by the therapist as a result of the legal action.
8. Filing a document with the court: $100
9. The minimum charge for a court appearance: $1500

Even though you are responsible for the testimony fee, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500).

INCAPACITY OR DEATH

I understand that, in the event of the death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT

By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, I will not render services to your child until I have received and reviewed a copy of the most recent applicable court order.

My signature affirms that I have read or heard the information above and that it was presented to me in clear, non-technical language. This information is understood by me and enables me to make an informed voluntary consent to counseling for myself (or my child if said child is the client). I understand that my case may be shared with the above named supervisor as apart of training.

Client's Name	Client Signature	Today's Date
Parent's Name	Parent Signature	Today's Date

Michelle Ezell, Today's Date
Licensed Marriage Family Therapist Associate
Under Supervision of Dr. Russ Bartee, PhD, LMFT-S, LPC-S