TheVillage.Love
Play Therapy & Counseling

DISCLOSURE STATEMENT AND CONSENT TO TREATMENT

I am glad that you are here, and I am committed to providing you with quality care. Please take a few minutes to read the following information that will explain my office policies and procedures to you. If you have any questions, please ask and I will be happy to clarify any of the information in this form. Please sign and date this form acknowledging that you have read and fully understood the information and are consenting to begin therapy with me.

Client's Name: _____ Date of Birth: _____

I _____, hereby give full consent for my child, _____ (the client), to receive services of _____ (the therapist) until I notify them or if they determines that services are no longer appropriate or will no longer be provided.

Confidentiality

_____ (INITIAL). My therapist follows the ethical standards prescribed by state and federal law, and her professional governing organizations. My therapist is required by practice guidelines and standards of care to keep records of my therapy. All of our communication becomes part of my and/or my family's clinical record. These records are confidential pursuant to certain legal and ethical limits and clinical parameters, and the HIPAA Notice of Privacy Practices provided to me. Within these limits, the information revealed by me during the course of therapy will be kept confidential. There are some situations in which my therapist is legally required to report and/or breach confidentiality. Possible legal exceptions to confidentiality include, but are not limited to, the following situations:

- If I reveal information that indicates I am a danger to myself or someone else necessitating a duty to protect or duty to warn.
- If I reveal information about child abuse, neglect, elder abuse or sexual exploitation.
- If my therapist receives a subpoena or a court order to disclose information.
- If I provide written permission or direction to release my record.

If my therapist feels that my child is in danger or is a danger to someone else, she will notify me and/or appropriate authorities.

211 Brooks St. Sugar Land TX 77478
Phone: 281-302-6252
judi@thevillage.love thevillage.love
sophie@thechildspace.com thechildspace.com

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_____ (INITIAL). For all individuals, privacy in psychotherapy is crucial to successful progress. When necessary, my therapist prefers to release only summaries with general information, treatment goals and progress, and attendance. My therapist shares office space at 211 Brooks Street with another clinician, therapists discuss client cases at times. Client names or other identifying information are never disclosed and confidentiality is maintained.

My complete record will be retained for seven years after I have completed treatment. At the end of seven years, the record will be entirely destroyed. The time period begins from the date of the last visit (or for minors from the date they reach 18).

Financial Policy

_____ (INITIAL) Payment is accepted using cash, check, Visa, MasterCard, and Discover. Failure to pay fees for counseling will result in termination of treatment after appropriate notice and suitable referrals are provided. Fees for counseling/psychotherapy services are as follows:

Fee Schedule

Description of Service	Licensed Providers
Initial intake and assessment 90 mins (adolescent)	$275
Initial intake and assessment 60 mins (child)	$225
Adult, individual or family sessions 60 mins	$195
Individual or play therapy 45 mins	$150
Individual or play therapy 30 mins	$95

$1.00 per for Copying Records
Legal Fees: Phone time, letter writing, court appearances, travel, $400 per hour.
Court appearance $1,500 for up to 4 hours retainer paid in advance

_____ (INITIAL) I am responsible for any legal fees that my therapist incurs as related to my case or treatment. Court/Deposition fees incurred include time for travel, preparation, and actual appearance time, billed at the stated hourly rate, with a **4-hour minimum charge**. Payment is due and **non-refundable** 48 business hours in advance. Any additional time spent on the day of the court/deposition appearance will be billed within 24 hours and is expected to be paid in full.

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_____ (INITIAL) My therapist reserves the right to suspend services if there is an unpaid balance in my account. There is no charge for appointments canceled or changed at least 24 hours in advance. Appointments can be canceled via the Patient Portal, by emailing my therapist, or by calling 281-302-6252. Please note that no-show appointments or **those canceled with less than 24 hour notice will be charged the full fee of the scheduled appointment,** emergency situations notwithstanding. These amounts cannot be billed to or reimbursed by my insurance carrier.

_____ (INITIAL). Phone calls more than **5 minutes** in length will be charged my therapist's rate for the length of the phone call in 15-minute increments. Telephone conferences with me or other professionals on my behalf, will be billed to me at my therapist's standard hourly rate.

_____ (INITIAL). I understand I may be able to receive reimbursement through my insurance provider's out-of-network benefits, flexible spending account (FSA), or health savings account (HSA). If I choose to do so, my therapist can provide me with an itemized receipt of services. Requests must be made by email to judi@thevillage.love or sophie@thechildspace.com

_____ (INITIAL). Sessions are by appointment only. My therapist and I will decide on a weekly appointment time based on session availability. I am responsible for keeping my appointment and arriving on time. In the event that I am not able to keep my appointment due to illness, I can reschedule for another time within the same week. Appointments are typically scheduled back-to-back, if I am late, my time cannot be extended. My session will be held within the remaining time allotted and will have to end as scheduled.

Emergencies

_____ (INITIAL). The practice does not provide 24 hour crisis or emergency therapy services. In the event of an emergency, I will call 911 or safely transport the client to the nearest emergency room.

Termination of Therapy

_____ (INITIAL). The process of ending therapy, called "termination," it can be a very valuable part of the therapeutic work. Termination with clients is done over 3 sessions in order to model appropriate ending of relationships. I agree to meet with my therapist for the 3 final sessions to process the work together, celebrate improvement, and referral to another therapist, if appropriate.

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Legal Issues

_____(INITIAL). It is my therapist's policy not to get involved in legal issues or custody disputes as it impacts the therapeutic alliance with my child. Should I have the need for a custody evaluation, I will be referred to an outside clinician who specialized in legal or custody issues.

_____(INITIAL). I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during or after therapy terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litem, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system.

_____(INITIAL). I understand that if I subpoena my therapist, she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor. In cases of active litigation or post-divorce, anything released from the office in writing, goes to both parties/attorneys.

Social Media and Communication

_____ (INITIAL). My therapists are unable to accept friend requests or other social media contact from current or former clients on any social networking site (Facebook, LinkedIn, etc.). This is a violation of ethical boundaries and can compromise my confidentiality and our respective privacy.

I authorize my therapist to send appointment reminders to the following email address:_____ . If I choose to use email for communication, I understand it may compromise the confidentiality of my information in ways my therapist cannot control. We may utilize unencrypted email as a means of communication on a limited basis, but my therapist will not engage in therapy over the Internet.

I understand my therapist may share a printer with other therapists and that those therapists will work together to ensure my privacy to the best of their ability. I understand the security of client information is not guaranteed when information is left on a voicemail, texted or emailed.

Any type of audio/visual recording is prohibited in therapy sessions.

Consent to Treatment

_____(INITIAL). By signing this Client Information and Consent Form as the Client or Guardian of the 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 receive mental health treatment and services for me (or my child if my child is the client) from my therapist. I understand that I may stop such treatment or services at any time.

_____(INITIAL). My therapist's attorney will be in attendance for any depositions and possibly court hearings, if my therapist believes it to be necessary. I am responsible for any and all legal fees incurred as related to my case.

_____ (INITIAL). I understand that I am responsible for my children's behavior. I agree not to leave children unattended at this facility for any reason. I agree to remain in the waiting room for the duration of the therapy session. While in therapy sessions, I/my child will not be allowed to harm themselves, others, or any property. If I/my child become a threat of harm to any of these, the authorities will be notified immediately and I will be held responsible for any damages incurred.

_____ (INITIAL). Under no circumstances will I hold the therapists, property, or property owner liable for loss or damage to my personal property on or around the premises. I release from liability and waive my right to sue my therapists, their employees, property, and property owner from any and all claims, including claims of negligence, resulting in any physical injury, illness (including death) or economic loss I may suffer or which may result from my participation, or any events incidental to participating in therapy.

By means of my signature, I hereby release my therapist and her staff from all suit, libel, damages or legal litigation of any kind that could be brought against them for any reason by us on our behalf. Your signature below indicates that you have read, understood, and agree to the above policies

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Therapist Signature _____ Date _____

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