Informed Consent for Individual or Group Psychotherapy

Thank you for considering Good Help Clinic as your provider for psychological services. The purpose of this consent form is to clarify clinic policy regarding the following issues:

Confidentiality: State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. A situation in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you sign a release of confidential information. This may be required by your insurance company or if you are involved in litigation.
5. If I receive a court order demanding access to your records.
6. Clients being seen in family or group therapy are not legally obligated to respect the confidentiality of others. The therapist will maintain confidentiality but cannot make assurances about whether your confidentiality will be maintained by others.
7. The therapist may on occassion speak with professional colleagues about your situation without asking for your permission. If that does happen, your identity will not be revealed.
8. Clients under age 18 do not have guarantee of confidentiality from their parents. Limits of confidentiality will be worked out up front with parents/guardian of clients under the age of 18.
9. It is also important to be aware of other potential limits to confidentiality that include the following:
    a) All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
    b) Cell phones, portable phones, faxes, and e-mails are used on some occasions.
    c) All electronic communication compromises your confidentiality.

Cancellations: Clients are responsible for the charges associated with therapy appointments. We require 24hrs advanced notice for cancellation. If you are unable to attend a scheduled appointment, please notify our office 24hrs before the scheduled appointment time in order to avoid charges. Being more than 15minutes late for an appointment without calling is considered a no-show. Insurance companies cannot be billed for missed sessions, so charges for missed sessions will be your responsibility. No-show will be billed at a rate of $50.

Insurance Reimbursements: If you have insurance and want us to, our clinic will file directly with your insurance company for reimbursement. This saves you time and out of pocket expenses. However, if there are problems with the insurance company, you will be asked to make the payment directly to Good Help Clinic and to work out the issues with your insurance company.

Fees: Fees are $120/hr for individual therapy. Sessions that extend beyond 1hr will be billed accordingly. Psychological assessment averages $450 for a standard battery, but prices may vary according to specific testing requirements. Fees for GHC services are posted on the goodhelpclinic.com website.

Availability: Appointments are scheduled in the evenings. If you need to contact me, the clinic telephone is the best way: 254-295-1742. Email is not monitored as carefully as telephone messages.

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not filled (such as seeking consultation, refraining from dangerous practices, coming to sessions sober, etc.), or if some problem emerges that is not within the scope of competence of the therapist. The usual minimal termination for an ongoing treatment process is four to ten sessions but a satisfying termination to long-term work may take a number of months.

Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need of psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy and therapy may be emotionally painful at times. Patients have the right to refuse or to discontinue services at any time and complaints can be addressed to the Texas State Board of Examiners of Psychologists.

Emergency Service: If you have a serious life-threatening emergency it is best to call 911 first, or go to your nearest emergency room. You are free to call me after you have engaged these emergency services.

Other Therapist Affiliations: Dr. Pendleton has other affiliations in the Temple area. He is employed by the Veterans Administration Hospital as a consultant for staff training and behavioral medicine. Dr. Pendleton is also an assistant professor with the TAMHSC.

Agreement for Psychotherapy Consultation: I have read this informed consent completely and have raised any questions I might had about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations. I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of his/her professional association as well as the laws of the state of Texas governing the practice of psychotherapy.

Being of sound mind, I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with Good Help Clinic, including appropriate compensation for staff time involved in preparing for and doing court work. I understand that my therapist may, on occasion, make teaching and research contributions using disguised client material. By consenting to treatment I am giving consent to this process of professional contribution and the right to use disguised material without financial remuneration.

Client Signature______________________________ Date _____________

Therapist Signature ___________________________ Date_____________

Parent/Guardian Sig _________________________ Date _____

Person you give permission to Victor Pendleton, Ph.D. to communicate with in the event of an emergency such as danger to self, danger to others or severe psychological distress:

Contact Name: ____________________ Relationship to you: __________________

Phone: _____________________ Address: ________________________________

Second Contact Name: ______________________ Relationship: ______________

Phone: _____________________ Address: ________________________________

Statement of the Therapist

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. My impression is that _________________________ is in a sufficiently stable mental state give an informed consent at this time.

Date________________ and Initial of Therapist __________.

This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties.