POLICIES, GENERAL INFORMATION & CONSENT
FOR TREATMENT & PSYCHOHERAPY SERVICES
Intuitus Group Counseling Clinic, PLLC

Monika (Niki) Montecillo, LPC-Intern #75531
Supervised by Jennifer A. Madere, LPC-S #62514
1464 E. Whitestone Blvd. Ste. 2001 - Cedar Park, TX 78613 - www.intuitus-group.com

Please read and initial next to each paragraph:

_____ **CONFIDENTIALITY**: All information disclosed within sessions and the written records pertaining to those sessions *are confidential* and may not be revealed to anyone without your (client or parent's) written permission, except when required by law. I am required to report any known or suspected child or elder abuse or neglect, and to take action to ensure safety if a client presents danger to self or others.

As required by the Texas State Board of Examiners of Professional Counselors, I work with the supervision of Jennifer A. Madere, LPC-S. I meet with my supervisor on a weekly basis to ensure the counseling received by my clients is of the highest ethical and clinical quality. As a Licensed Professional Counselor Intern, client files are owned by and payment for counseling services is made to Intuitus Group Counseling Clinic, PLLC.

For educational and professional purposes, I consult regularly with other professionals regarding clients in order to ensure quality of my service; however, a client's name or other identifying information is never mentioned. For educational, research or business purposes, I may collect and share information that is "de-identified" (i.e. it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you). Please see HIPAA Notice for more information.

_____ **EMERGENCIES**: If you are unable to reach me in an emergency, you or someone you trust should call the local emergency room, your medical doctor, or 911. If I assess you may be at risk to harm self or others, I may contact your Primary Care Physician, your emergency contact, or emergency personnel to advocate for your care and safety.

If I become unable to serve or contact you due to personal emergency, serious illness, or death, the following persons will be available to help or refer current clients, and manage client records:

Jennifer A. Madere, M.A., LPC-S - (512) 762-4762 or Christopher L. Sperling, M.A., LMFT-S – (512) 587-1784

_____ **HEALTH INSURANCE - CONFIDENTIALITY OF RECORDS & PAYMENT:** I will not bill for your psychotherapy sessions to your insurance. If you request a receipt to submit for reimbursement, the full session fee is due on the date of service and by law I cannot offer a discounted fee. It is your responsibility to verify the specifics of your coverage. Your health insurance may require confidential information from me to process claims. In this case I will notify you and obtain your consent before releasing the requested information. Be advised that some insurance companies do not reimburse for services rendered by LPC-Interns.

_____ **YOUR RIGHT TO REVIEW RECORDS/ HIPAA NOTICE**: You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when releasing information might be harmful in any way. In such case, I will provide the records to a licensed mental health professional of your choice. Considering the above exclusions, I will release information to any entity you specify only upon receiving your written authorization. My HIPAA and HB300 Notice of Privacy Practices are posted on my website. You may request a copy for your records if desired.

_____ **LITIGATION LIMITATION**: Due to the sensitive nature of therapy and the information shared and addressed, I am not obligated to supply any documentation, correspondence, or presence regarding any legal proceedings. Should you or your attorney desire any documentation or service for court/legal purposes, I must receive such request in writing and by law have 15 days to give a response. I may decline the request if disclosure of the requested information may be harmful in any way to the client; no request will be acknowledged unless it is accompanied by the client or guardian's written permission. Any documentation, consultation, or testimony requests will incur a charge of $50 per half hour. Testimony charges may include time spent traveling, preparing reports, attendance, and other case related costs.

_____ **DUAL RELATIONSHIPS**: Dual relationships should be avoided whenever possible, especially when ethics or your treatment progress may be in question. Therapy *never* involves sexual or any other dual relationships that may impair my objectivity, clinical judgment and effectiveness or could be exploitive in nature. Should we encounter each other anywhere outside of my office, I will not approach you or acknowledge you unless you initiate contact, and will not discuss therapeutic issues at that time.

_____ **THE PROCESS OF THERAPY**: Participation in therapy can result in benefits to you, including improving relationships and resolution of specific concerns or symptoms that led you to seek therapy. Working toward these requires effort on your part both in and outside of sessions. Although therapy has been shown to improve relationships and symptoms, it may create uncomfortable feelings in the short-term. For example, addressing unpleasant past experiences can result in experiencing discomfort or strong feelings. Please inform me if such issues arise. Therapy is most likely to be successful with your active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. During the course of therapy, I am likely to draw from several psychological approaches according to the problem being treated, my training, and my assessment of what will benefit you. These approaches include cognitive-behavioral, and psychodynamic therapies.

_____ **MINOR CLIENTS:** Parents have a right to receive progress reports on their child's counseling. However, personal information shared by a child during an individual session will be kept confidential unless it involves imminent danger to the child or someone else. Young people may not confide in a counselor if they believe that personal information will be revealed to their parents. If applicable, I must receive a copy of the most recent divorce decree or custody order at our first session; this is to ensure proper consent, confidentiality and disclosure of information. All parent/guardian parties must be informed of treatment, and all with custody rights must consent to treatment of minor at or prior to the first session. Exceptions to parental consent may apply to minors 16 years or older who present for emergency counseling regarding sexually transmitted diseases, substance abuse, pregnancy issues, and/or are emancipated.

_____ **DURATION & TERMINATION**: The duration of treatment depends entirely on your presenting concerns, treatment goals we develop together, and effort toward those goals in and outside of sessions. We will discuss goals and course of treatment periodically, with initial goals/focus developed by the 3rd or 4th session. I request notice before therapy is terminated in order to process gains made during treatment, and issues to be addressed in the future. Therapy will be deemed "Terminated" if client has met all therapy goals and attend a termination session. I consider a client "Inactive" if no session has been scheduled or attended for 60 days, unless a different therapy schedule has been agreed upon. Inactive clients may contact me to resume therapy, and will be accommodated according to my current policies, fees and availability at that time.

_____ **PAYMENTS & FEES**: Payment by cash, check, or credit card in the amount of your fee is due at each session. Make checks payable to **Intuitus Group Counseling Clinic, PLLC**. My fees are $100 for the initial session. Subsequent fees are $100/hour for couple or family therapy, and $80/hour for individual therapy. Sessions are one hour in length, and include approximately 5 minutes for me to complete documentation after the session. I may offer a limited number of discounts based upon client need and my availability. Discounted fees are not eligible for reimbursement by insurance. Telephone conversations, report writing/reading, release of information, longer sessions, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments. A fee of $35 will be assessed for returned checks.

_____ **PHONE CALLS & E-MAIL**: If you need to contact me between sessions, you may call or e-mail me to make, cancel, or reschedule an appointment, or make brief reports about your progress. If you have an urgent, need please call me and state such in your message. Therapy issues or crises will not be addressed by e-mail. I check my phone and e-mail messages between 9:00 a.m. and 6:00 p.m., Monday - Friday (excepting holidays/vacations). Messages will be returned by the end of the next business day. Please do not use text messaging to communicate with me, as it is not a secure way to transmit information. Please list your preferred email and phone contact:

Email: _____ Phone: _____

_____ **CANCELLATION**: Your full fee is charged for "no shows" and appointments cancelled less than 24 hours before the scheduled time. An appointment is considered cancelled when not attended at the agreed time/date, and not rescheduled and attended within the same calendar week as the original appointment. Third parties do not reimburse for missed or cancelled appointments. Payment is due for any missed appointment at the beginning of the next session.

CLIENT/GUARDIAN: I have carefully read, understand, and agree to comply with the above policies and information, and consent for treatment and psychotherapy services with Monika (Niki) Montecillo, LPC-Intern #75531. I agree to participate in therapy:

___ Weekly
___ Bi-weekly
___ (Other): _____

Preferred session length:

___ 60 Minutes
___ I am interested in intensive therapy options
___ (Other): _____

I understand that my fee for services per session will be _____ for the first session, and _____ per session thereafter unless agreed and noted otherwise. My fee for missed sessions or cancellations less than 24 hours in advance will be the same amount.

Client Name (Print)_____ Date_____ Signature_____

Parent/Guardian Name (Print) _____ Date _____ Signature _____

Parent/Guardian Name (Print) _____ Date _____ Signature _____

I have discussed the above issues and policies with the client/parent(s). My observations of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent to treatment.

Monika Montecillo, LPC-Intern #75531 Date_____ Signature_____

Supervised by Jennifer A. Madere, LPC-S #62514