TERESA KHOUW, MA, LPC, RPT

Informed Consent

Welcome

I welcome you! It is my desire to ensure that your participation in counseling will be a most productive and satisfying one. In order to facilitate a therapeutic relationship, I have set forth certain information which will enable you to make an informed consent to counseling.

Therapist My name is Teresa Khouw. I am a Licensed Professional Counselor and Registered Play Therapist. The Texas Behavioral Health Executive Council at 333 Guadalupe St., Ste. 3-900 in Austin, Texas 78701 licenses me to provide mental health services. I am also a member of the Texas Counseling Association, American Counseling Association, Association for Play Therapy and the Texas Association of Play Therapy. I am in private practice and operate as an independent practitioner.

Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you will achieve change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded conceptualizations of your life, relationships, circumstances, and future, 3) move toward resolving your concerns, and 4) forge a plan that promotes greater realization of your human potential, happiness, and success. As your counselor, using my knowledge of human behavior and the human change process, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur.

Appointments

Persons are seen in the office on an appointment-only basis. Appointments may be made by calling or texting (972) 365-8165. I maintain my own appointment calendar. Adult appointments are usually 45-minute sessions. Children's session lengths may vary depending on the age-appropriate length for the child, such as a 3-year-old may have a 30-minute session and a 10-year-old may have a 45-minute session. As the therapist, I reserve the right to act on the child's behalf and gear the session length according to the child's needs.

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged a **$50 fee** for that missed appointment. You are responsible for contacting me to cancel or reschedule your appointment. Please understand when you make an appointment you are reserving a time. As your therapist, I have agreed not to utilize that time slot for any other purpose. If you fail to keep your appointment and fail to give adequate notice, I am unable to schedule another use for that part of my workday.

Number of Visits

The number of sessions needed varies and depends on many factors, which we will discuss in session.

Please initial indicating you have read & understand this page: _____

Relationship

Your relationship with me is professional and therapeutic. In order to preserve this relationship, it is imperative that I have no other relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I care about helping you but I am not in a position to have a social or personal relationship with you. Gifts, bartering and trading services are specifically disallowed in the legal code of ethics in my profession. In the event that our paths cross in social or public settings, our therapeutic relationship comes first. In order to protect your confidentiality, I will not initiate a greeting. [1]

Payment for Services

If for any reason your Insurance does not cover mental health outpatient charges, you will be expected to pay provider in full **$125** per session.

If you have no insurance benefits you are expected to pay for the session at the time of service. Payment for services may only be made by cash or credit card in the amount of **$125 per session** as discussed with provider prior to 1st session.

If you request Teresa Khouw, MA,LPC,RPT to write a letter, such as to your child's school for assessment or diagnosis purposes, a fee of **$100 per letter** is payable by cash or credit card upon request.

Court Proceedings

Although it is my goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. Should you subpoena TERESA KHOUW, MA, LPC, RPT as a factual witness or involve me in court-related processes, you will be charged a **retainer fee of $3,000 with a charge of $300 every hour** therapist is involved in case preparation, phone calls, travel, and witness time, etc. Should you issue TERESA KHOUW, MA, LPC, RPT without her approval, the subpoena will be directly turned over to her attorney and a bill will be rendered to you for immediate retainer fee payment.

Confidentiality

Discussions between a therapist and a client are confidential. Confidentiality of client information is governed by federal law (Health Information Portability and Accountability Act) and by state law.

Please initial indicating you have read & understand this page: _____

No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health party is an issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to my attention in the beginning of the first session.

Minors have a limited right to privacy in that their parents may have access to their records. However, if the therapist believes that sharing this information will be harmful to the child, confidentiality will be maintained to the limits of the law.

By signing this information consent form, you are giving your consent for me to share confidential information with all persons mandated by law and with the agency that referred you and the managed health care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless this therapist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event my therapist reasonably believes that I, the undersigned client, am in danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name	Relationship	Phone Number

I, the undersigned client, consent for my therapist to communicate with me by mail and by phone at the addresses and phone numbers I have provided on the personal information form, and I will IMMEDIATELY advise TERESA KHOUW, MA, LPC, RPT in the event of any change.

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of

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effort you are prepared to give to this endeavor.

Recording of Sessions:

I am aware that my counseling sessions are being audio and video recorded. These recordings along with all materials and matters discussed during counseling are confidential and private and will not be released without my written permission. _____ (initials, please)++

Therapist's Incapacity or Death

I, the undersigned client, acknowledge that, in the event my therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my files and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by my therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

Client/Parent or Legal Guardian Signature Date

Emergency Services

I am unable to provide services 24 hours per day, seven days per week. In the event that you become in need of emergency services when I am unavailable, you may call 9-1-1 or go to the nearest emergency room.

Consent to Treatment

I, the undersigned client, voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. However, premature termination may result in failure to achieve therapeutic outcomes. By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client/Parent or Legal Guardian Date

Informed Consent

My signature below indicates that I am consenting to treatment by TERESA KHOUW, MA, LPC, RPT and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA). If I have questions, the information has been explained and/or summarized for me

Client Signature: _____ Date: _____