Solomon Family Services
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Counseling Services, Polices and Informed Consent

Welcome, I am pleased that you have selected **Solomon Family Services** for your counseling needs and have chosen to work with me as your therapist. This document is designed to inform you about my office policies and to insure that you understand our professional relationship.

I use a holistic approach to counseling which takes into account the spiritual, psychological, social and biological dimensions of the client. The relationship we establish will be characterized by mutual respect and cooperation. Our mutual goal will be that you and or your child will grow, develop, and be committed to working on things we talk about both during our sessions and at home. My ultimate goal is that you and or your child will come to a place of being able to resolve your own issues and / or live with manageable pain without my assistance or intervention. I will offer you and or your child tools in which you can utilize in the achievement of this goal.

Psychotherapy and or play therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you or your child may experience discomfort like feelings of sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy and or play therapy has also been shown to have many benefits. Therapy often leads the client to having better relationships, solutions to specific problems, and significant reductions in feelings of distress. Please note however, that it is impossible to guarantee any specific results regarding your counseling goals. Together, however we will work to achieve the best results possible.

Please feel free to talk with me if you and or your child should ever feel uncomfortable. This will help the therapy process and help you be more confident regarding your or your child's treatment. Please feel comfortable to ask questions as they come up. I am pleased you and or your child have come for counseling and look forward to getting to know you. If at any time you are dissatisfied with my services, please let me know. If you are unable to resolve your concerns, I will be available to refer you to another therapist or agency that may be able to help you. If you feel I have acted in an unethical or immoral manner, you may call the LPC or LMFT board at (800) 942-5540.

Number and Length of Visits

The counseling process is different for every person. Some clients may have counseling for 6-10 sessions and feel they are significantly helped. Others may need longer-term therapy. The number of sessions depends on many factors and will be discussed between us. Therapy sessions are 45-50 minutes in length.

Relationship

This is a professional therapeutic relationship and I cannot accept gifts from you or your child. In public, I cannot acknowledge you or your child unless you or your child acknowledges me first. In that case, there cannot be any conversation of a clinical nature between us outside of a therapy appointment.

Payment for Services and Fee Agreement

The charge for the initial session is $125.00. Additional sessions are charged at a rate of $100.00. By consenting to treatment, you acknowledge that you are responsible for the cost of these provided services. Payment is due at the conclusion of each session. Payments may be made by cash, check, Visa or MasterCard. There is a $25.00 service charge for all returned checks. If your account is not paid, then you agree to pay a service charge after 30 days notice and if collection services are required, you agree to pay attorney fees and /or collection fees and expenses. I have the right to terminate treatment if fees are not paid in a timely fashion. If rates should increase in the future, I will advise you at least 60 days prior to any increase. If at any time you have questions about the fees please feel free to discuss them with me.

Insurance

I do not file insurance. However, you have the option of filing your own insurance. The receipt provided at the end of each session contains the information needed to file a claim. You can contact your insurance company for the information on how to file your insurance. Due to variations in policies, we cannot guarantee payment by your insurance company. If you lose your receipt and need a copy let me know.

Legal Responsibilities

IF legal actions occur in which I am requested or subpoenaed to provide testimony you will be responsible to provide the following even if the subpoena is sent from the opposing side of the case and even if our ongoing relationship has ended: A more detailed description regarding fees for court services is out lined in the Court Services letter of agreement.

1. Travel Expenses (gas, parking, etc.)
2. Hourly rate of $100.00 from the time I leave the office until I return.
3. A minimum four hour minimum charge must be paid in advance.
4. Telephone consultations with attorneys are at the rate of $100-00 per hour or part thereof.

Cancellations

Should you need to cancel your appointment, please call at least 24 hours in advance. **Except** for emergencies, the normal fee will be charged for missing appointments if not given 24 hours notice. (Voicemail is available 24 hours a day, seven days a week).

I understand that fees for all services are due at the time of my appointment. I also understand that the normal fee will be charged for missed appointments if my therapist is not given a 24 hour advance notice. **Initials**: _____

I recognize the occasional need for a phone call and I'm happy to offer a response in a timely manner. Telephone calls, which exceed 15 minutes, will be charged by the half hour on a pro-rated basis.

Emergencies

Should you need emergency assistance after hours, you may go to the nearest hospital emergency room, call 911 or call the 24 hour Mental Health Crisis Hotline at 972-562-7722, the Suicide & Crisis Center at 214-828-1000, or the Counseling and Crisis Line at 214-233-2233. For non-emergencies, you may leave a message and I will return your call in a timely manner.

Confidentiality

Everything that is communicated within our sessions is confidential information and cannot and will not be communicated to any other person or organization without your expressed written consent. This confidentiality applies to any and all records of your identity, diagnosis, session or progress notes, evaluation, treatment or treatment plan, as well as any information communicated by phone, fax, or email.

Please note: ***confidentiality will not be observed with respect to the following conditions:***

1. You direct me by means of a signed and dated written consent form to disclose information to a person or organization of your choice, (please note: if you enter therapy as a married couple, both signatures will be required in order to release confidential information).
2. I determine you and or your child are a danger to yourself and or others, in which case I am required to inform a medical or law enforcement agency.
3. I become aware of abusive or neglectful behavior toward a minor.
4. I become aware of abusive, neglectful, or exploitive behavior toward the elderly or disabled persons.
5. I am ordered by a court to disclose information.
6. I need to utilize the services of a collection agency for any unpaid balance (no clinical information will be provided, only contact information), or
7. I find it helpful to seek counsel from another mental health professional in order to help you more effectively seek recovery and emotional healthiness.
8. You (parent or legal guardian) sign a written consent.

9. I may engage staff or an Administrative Services provider to assist in the administrative aspects of handling you case. To the extent the law allows, they will be bound to honor all confidentiality. It is important to remember that if you choose to utilize your insurance, we will be obligated to provide them certain information about your case including (but not necessarily limited to) a diagnosis, type and dates of service, By assigning benefits to me you are authorizing me to provide your insurance carrier (or its intermediary) whatever information is necessary to process the claim. If you choose to utilize your insurance, it may affect your insurability. You are also authorizing the use of this signature for all insurance submissions and authorizing that this authorization will cover all mental health services rendered until you revoke such authorization and that a copy of this form may be used in lieu of the original document.

10. If you or your child receives concurrent services from another practitioner, we are both obligated to disclose our involvement to one another.

_____

Client –Print Name Date

_____

Client-Signature Date

_____

Counselor- Signature Date