Dr. Beau A. Nelson, DBH, LCSW
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Counseling and Psychotherapy
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972-980-9911

Please read and sign to acknowledge your agreement.
You may download a copy of this form and all the documentation for this office at improveyourmood.com.

CONSENT TO TREATMENT

A "therapist-patient" or "treatment" relationship does not exist until after initial assessment is completed and we have decided to move ahead as evidenced by your signature on this form. It is important that we both agree that we are a good match in working together towards your goals. We will discuss this during the first visit and decide whether or not to proceed, and whether we need to continue the assessment for one or more subsequent visits. It is also important for you to be aware of the benefits and limitations of psychotherapy or other services you will be receiving. While it is generally expected that you will benefit from therapy, there may be periods of feeling worse before feeling better and there is no guarantee of success in therapy. There may be alternative treatments or modes of therapy to consider. I encourage you to become aware of these factors and to ask any questions you may have at any time during our work together.

CONFIDENTIALITY

State law protects the confidential nature of the therapist-patient relationship but this protection is not absolute. I will not release clinical information to anyone unless given written permission to do so by the patient (or if the patient is a minor, by his or her parent or guardian). However, there are a few exceptions that allow or require the release of confidential information even in the absence of patient consent.

Examples Include:
1) The therapist must act appropriately when there is danger to the patient or to another person at the patient's hands. This generally means that the therapist may involve others when necessary to protect the patient if he or she is suicidal or is unable to provide self-care at a level necessary for basic survival, or to prevent harm to another person. State law also requires the reporting of abuse to or neglect of a child or an elderly or disabled person when there is reason to believe it has occurred.

2) In response to a *court order*, the therapist must testify or release records. However, a therapist does not release records, depose or testify in response to a *subpoena* unless the patient or patient's guardian has given written authorization to do so or if the therapist is required by law to do so.

3) As professionals, we do consult with one another from time to time. Any clinical material is conveyed without identification whenever possible. At other times, it will be necessary (for example, if another therapist is covering calls during a vacation). Finally, case material is sometimes used in training, research, writing, etc. This is always done with identifying information removed and with great care and respect for your privacy. Any other release of information requires you or your guardian's written authorization.

OFFICE & FINANCIAL POLICIES

Fees: Payments are due at the time services are rendered; payments will be received at the beginning of each session. It is up to the discretion of the therapist to allow for a deferred payment.

Insurance: We will be glad to provide necessary documentation for filing insurance claims. The therapist may bill excessive insurance paperwork demands separately after consultation with the patient. Generally routine notes or other documentation will not be considered excessive. However, you will be responsible for the full fee at the time of service unless we make other arrangements. Information regarding out-of-network payments is available and we will work to help answer any questions you may have regarding reimbursement through your insurance carrier.

OFFICE & FINANCIAL POLICIES CONTINUED

Emergencies: I do not provide formal emergency services, yet I wish to be as available as much as is reasonably possible. You may call the office number at any time and leave a message if I do not answer. During the business day I can often, though not always, return calls fairly quickly. Nighttime and weekend calls will usually be returned the next business day. If you find yourself in an urgent situation, make a judgment about the prudence of waiting for my call versus calling 911 or going to the nearest emergency room for immediate care. If I am away for more than a day, my voice mail message will indicate that and state my expected date of return.

Death or Incapacity: In the event that the therapist dies or is otherwise incapable of providing for the clinical services of this office the patient consents for the therapist to designate Raymond Castilleja, LMSW as conservator for the records of this office, including all patient records, and at the time of death or incapacity of the therapist he will take possession of the patient records and make those available to the patient or a mental health professional of the patient's choosing at such time that a written request is made to this office.

Complaints: We strive to always provide competent and professional services to our patients. From time to time there may be an issue that we need to address. Please notify the office immediately of any problems or complaints and we will work with you to solve these together. If we are unable to reach a satisfactory solution you can direct inquiries to the State Board of Social Worker Examiners at 1100 West 49th Street, Austin, TX 78756-3183 or via telephone at 800-232-3162.

Other fees: If report preparation is requested or required, the time rate charged for our therapy sessions will apply. Extended or frequent telephone contact will also be charged for. These services are not usually reimbursed by insurance. I will not agree to court appearances or other legal involvements unless we have discussed the matter thoroughly and both agree that such involvement is within my range of competence and will not interfere with the treatment relationship. Professional fees for court appearances, depositions and attorney consultations are $300 per hour including travel and waiting time, are non-discountable, and are payable in advance only.

Accounts: Payment may be made with cash, credit card, or by check. I do not extend credit. In any such arrangement, late payment fees of $10 per month will be charged on any balance not paid within 30 days. I do not depend on an outside collection service unless accounts are overdue by 90 days. I would much rather communicate with patients and find some solution to overdue accounts. Patient hereby consents to the delegation of collection activities to an outside collection agency, including the release of necessary information required by the collection agency. A delinquency fee of 40% of the outstanding balance will be added if a collection agency is required. There is a returned check processing fee of $25 in addition to reimbursement for charges assessed by my bank. Statements, receipts, or other documentation will not be issued to any delinquent account until paid in full. Payment by credit cards will be in accordance with the pre-authorization for health care form provided by this office.

Missed appointments: Unless waived by mutual agreement on a case-by-case basis, no-shows and cancellations will be charged for unless you cancel at least 24 hours in advance of the appointment time. The fee for late cancellations (less than 24 hours notice) is 50%, and for no-shows 100%, of the full fee. Patients arriving 15 minutes or more late to the appointment will be considered a no-show and must be rescheduled unless other arrangements are made with the therapist. Authorization is given, where applicable, to charge credit/debit cards for late or no-show appointment fees when incurred. Patient understands the appointment policies of the office and assumes responsibility for payment of fees related to late cancellations or no-show appointments. Such charges are payable immediately and will be automatically deducted, where applicable, and are not normally reimbursable by insurance.

Please sign below indicating that you have read, understand, and agree to the information and terms on both pages of this document.

_____ _____

Signature of patient or other responsible person Date

_____

Print name