Karis Counseling LLC – Kathy Pardue LPC
105 East Main St., Brenham, TX. 77833 713.501.0663 www.kathyparduelpc.com email: info@kathyparduelpc.com

INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

Thank you for selecting me to be your therapist. This consent is designed to inform you about what you can expect regarding confidentiality, emergencies, and other details regarding your treatment. Though this document is an ethical obligation, it is part of my commitment to keep you fully informed of your therapeutic experience.

Background Information

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask.

- License #17184 Texas Behavioral Health Executive Council, 2001. Private Practice since 12/2002.
- Education: BA-University of Houston, 1978 MA-Counseling, Prairie View A&M University, 1998; Post-graduate work at Dallas Theological Seminary (1986-87); University of St. Thomas-St. Mary's Seminary, Houston, 2009.
- Specialties: Individual Therapy-CBT, (Cognitive Behavioral Therapy); Couples Counseling-EFT, (Emotionally Focused Therapy); Adolescent Therapy;
  Brief, Solution-focused Therapy, Critical Incident Stress Debriefing. Group Therapy for couples; Speaking on grief, ADHD, eating disorders, depression/anxiety, Hope in Despair. Northwest Assistance Ministries, Houston Center for Christian Counseling, and Cypress Creek Psychiatric Hospital.

Theoretical Views & Client Participation

It is my policy to see clients who I believe can resolve their problems with my assistance and prayer. As people become more aware, they are more capable of finding peace in their lives. You may end your relationship with me at any point. It is important for you to take an active role working on things we talk about during sessions. Please avoid alcohol or non-prescription drugs for at least eight hours prior to your sessions. If you are unable to keep your appointments or return for one month, I will need to close your chart, resuming treatment is an option if I have room in my schedule.

Confidentiality & Records

Your communications with me will is part of the clinical record and is your Protected Health Information (PHI). Your PHI will be stored in a locked cabinet in my locked office. I will always keep everything you say to me confidential with the following exceptions: (1) you direct me to tell someone and sign a Release of Information form; (2) I determine you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. My license does provide me with the ability to uphold what is legally termed "privileged communication." It is your right to have a confidential relationship with a therapist. If a judge orders the disclosure of your private information, the order can be appealed. I cannot guarantee the appeal but will try to keep your information confidential. In **Couples Counseling**, information revealed may be discussed with **either** partner. I do not keep secrets.

Professional Relationship

Our relationship is different from other relationships and is limited to only the relationship of therapist and client. In any other way, we would have a "dual relationship," unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and client's interests.

Providing a legal opinion is also unethical and dual relationship. You may hire a therapist specifically for a legal opinion, which is considered "**forensic**" work. I will provide therapy only and **not** forensic services. This means I will **not** participate in **custody** evaluations, **depositions**, **court** proceedings, or any other forensic activities. If for some reason I must testify in a court, I will require an upfront retainer of $3,000.00, and my billing rate will be $500.00 per hour, plus reasonable attorney fees. If I receive a subpoena to produce documents, I will need to charge you reasonable and customary fees based on state and Federal guidelines of $1.00 per page or maximum allowed by

Please initial that you have read this page _____

law to produce those records. If a summary of treatment is accepted, I charge a prorated hourly rate for the time to produce this summary and reasonable attorney fees.

I will not address you in **public** unless you speak to me first for confidentiality. I must also decline invitations to attend gatherings with your family or friends.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be given in a professional manner consistent with the American Counseling Association. I am unable to guarantee specific results regarding your goals, however, we will work to achieve the best results. Therapy may affect other people in your life, and you may feel somewhat worse when they first start therapy before you begin to feel better. For the safety all clients, I maintain a **zero tolerance weapons policy**. No weapon is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes. I have the right to contact law enforcement officials and/or terminate treatment.

TeleMental Health Statement

TeleMental Health is defined as follows: "TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information.
TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers."
Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

Landline telephones may **not** be completely secure. Individuals who have access to your phone or phone bill may determine who you talked to, initiated the call, and how long you spoke. If you have a **landline** and you provided me with that phone number, I may contact you on this line from my cell phone, typically **only regarding setting up an appointment**. Phone conversations are billed at my hourly rate.

Cell phones:

Cell phones may **not** be completely secure. There is a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your **cell phone bill** may be able to see who you have talked to, initiated the call, and where each party was located when that call occurred. I may use a cell phone to contact you **only** to set appointments. Phone conversations are billed at my rate. I will keep your cell number listed by your initials password protected.

Text Messaging:

Text messaging is **not** a secure means of communication and may compromise your confidentiality. **It is my policy to use texting for appointment confirmations only.** Please do **not** bring up any **therapeutic content** via text to prevent compromising your confidentiality. I am required to keep a **copy** or summary of all texts.

Email:

Email is **not** a secure means of communication and may compromise your confidentiality. **Please know that it is my policy to use email for appointment confirmations only.** Please do **not** bring up any **therapeutic content via email** to prevent compromising your confidentiality. I keep a copy of all emails. For TeleHealth clients, you may print and sign Intake, Informed Consent, and Privacy Policy. Please scan and return via email which is more secure.

Social Media - Facebook: It is my policy **not** to accept friend requests from current or former clients on my **personal** networking sites such as Facebook for confidentiality.

Blogs: I may post counseling information on my professional blog. If you follow me, be aware that the general public may see you are following my blog.

Video Conferencing (VC):

Video Conferencing may be used for remote sessions over the internet. I use Google Meet which is encrypted to the federal standard, HIPAA compatible. Please sign on five minutes prior to your session time. Please use a safe computer or device (firewall, no public internet, password protected, anti-virus.)

Please initial that you have read this page _____

Credit Card Transactions: **Credit Card payments are not received thru my website portal. You may pay with credit card present in my office using secure Bank of America direct deposit portal. Or, you may pay directly through Zelle, Bank of America service via my phone number, 713.501.0663. Or, you may also keep credit card information in your file in my locked file cabinet and locked office, and I will charge your card after our session. I must have your credit card information *prior* to TeleMental Health sessions and will charge your card *after* the session.**

Your Responsibilities for Confidentiality & TeleMental Health

It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that others or hackers could either overhear our conversations or access the technology you are interacting with. You also agree ***not*** to record any sessions.

In Case of Technology Failure

If we encounter a technological failure, I will contact you via phone. If we get **disconnected** from a video conferencing, **end and restart the session.** If we are unable to reconnect within ten minutes, please call me. If we are disconnected on the phone, please call me back. You will **not** be charged if my phone or computer is the problem.

Limitations of TeleMental Health Therapy Services

TeleMental Health services may have some limitations. There is a risk of misunderstanding one another due to lacking visual or auditory cues. There may also be a disruption to the service. I invite you to keep our communication open at all times to reduce any possible harm.

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing to include for your treatment. We will determine which modes are best for you. You may withdraw your authorization to use any of these services by notifying me in writing. Texting__ Email__ Video Conferencing__ Website Portal__

Communication Response Time

My practice is set up to see individuals who are reasonably safe. I am not available at all times. If this feels like insufficient support, we can transfer you to a therapist with 24 hr. availability. I will return phone calls, texts, and emails within 24 hrs. I do not return calls on weekends or holidays. If you have an emergency, please follow these guidelines:

In Case of an Emergency

If you have a mental health emergency, please do not wait for communication back from me, but do one or more of the following:

- 24 hour Crisis Hotline: For Texas teens- 800.989.6884
- Call your local hospital
- Call or text 988 Suicide Prevention & Crisis Line
- Call 911.
- Go to the emergency room of your choice.
- MHMR Authority of Brazos Valley– Crisis Services for counties: Brazos, Burleson, Grimes, Robertson, Leon, Madison, and **Washington**

If we decide to include TeleMental Health as part of your treatment, there are **additional procedures** we need to have in place specific to TeleMental health services. You understand that if you are having **suicidal or homicidal thoughts**, experiencing **psychotic** symptoms, or in a **crisis** that we cannot solve remotely, I may decide you need a **higher level of care** and TeleMental Health services are **not** appropriate.

- I require an **Emergency Contact Person** who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your **ECP** is willing and able to go to your **location** in the event of an emergency. If either you, your ECP, or we determine necessary, the **ECP agrees take you to a hospital**. We will only contact this individual in the extreme circumstances stated above. Please list your ECP:
  Name: _____ Phone: _____

Please initial that you have read this page _____

- You agree to **inform** me of the address where you are at the **beginning** of every TeleMental Health session.
- You agree to **inform** me of the nearest mental health hospital to your primary location that you prefer to go in a mental health emergency.
  Hospital: _____ Phone: _____

Structure and Cost of Sessions

Based on your treatment needs, I may provide face-to-face, phone, and video conferencing. The cost of both in-person sessions and TeleMental Health:
Individual: $80 per 50 minute session, $100 per 75 minute session, or $125 per 90 minute therapy session.
Couples/family: $100 per 50 min., $125 per 90 min.
The fee for each session is due at the **conclusion** of the session. Cash, Visa, MasterCard, Discover, American Express are acceptable for payment. A detailed **receipt** of payment is given and may be used for insurance if applicable to you. **Phone calls** are billed at my hourly rate. I require a credit card ahead of time for TeleMental Health therapy for ease of billing. Your credit card will be charged at the **conclusion** of each TeleMental Health interaction in your presence **or** in your absence.

Cancellation Policy

Please notify me 24 hrs. before our session if you are unable to keep our appointment to avoid session fee of $50.

Our Agreement to Enter into a Therapeutic Relationship

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form **as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you. I am looking forward to helping.

_____ _____
Client Name (Please Print) **Date**

_____
Client Signature

If Applicable:

_____ _____
Parent's or Legal Guardian's Name (Please Print) **Date**

_____
Parent's or Legal Guardian's Signature

_____ _____
Parent's or Legal Guardian's Name (Please Print) **Date**

_____
Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that they have discussed this form with you and has answered any questions you have regarding this information.

_____ _____
Therapist's Signature **Date**

Please initial that you have read this page _____