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counselingbydebbie@gmail.co

Debbie McGrath , LPC

INFORMED CONSENT

This form explains aspects of how I work. I encourage you to ask any questions you have about my way of working or about psychotherapy in general at any point in our therapy together.

Training and Background

I am a Licensed Professional Counselor licensed by the Texas State Board of Examiners of Professional Counselors. I am a lifeline educator, which is imperative to my professional growth.

I received my M.Ed. in Counseling from Tarleton State University. I'm also a certified school counselor with seven years of experience, 19 in the field of education with a Gifted and Talented Endorsement from the University of North Texas. I have completed additional training in Biofeedback, belong to several professional organizations and present at conference regularly.

Confidentiality

I will treat with great care all information you share with me. It is your right that our sessions and my records about you be kept private. In all but a few rare situations, your confidential information is protected by state law, the rules of my profession, and my personal integrity. Texas state law requires me to inform you that in certain cases your confidentiality is not protected, and your information may be disclosed to the appropriate authorities/agencies. These cases are:

If I have reason to believe that you may harm yourself or others, If I have reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability, or If I am ordered to disclose by state or federal courts. The Texas State Board of Examiners for Licensed Professional Counselors requires that I notify you who would maintain my records in the case of my death or disability. Debbi Dunbar, LPC is the named custodian of my records and she has agreed to follow the guidelines set forth by the above mentioned board.

_____ Client Initials

Additionally, I may disclose information if you sign a release form granting permission to designated third parties to receive information that you request me to share.

I will never disclose your information for any reason without your knowing of my intent.

Therapeutic Relationship

The relationship between therapist and client is the container through which change can take place. As such, the relationship is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. Because the therapist-client relationship is so important, I cannot be involved in a social relationship or friendship that exists outside of the therapy room. Limiting our relationship to the therapy office keeps your therapeutic environment safe, secure, and free of outside complications that could interfere with therapy.

The Therapeutic Process, in my view, working with clients entails tailoring therapy to meet the needs of each client individually. I have worked with clients experiencing anxiety, trauma, and relationship difficulties. My approach to therapy includes a strengths based approach while using Cognitive Behavorial Therapy techniques.

Fees

My fee is $150.00 per 50-minute session. Payment in full is due at the time services are rendered. Please make checks payable to "Debbie McGrath."

If I am subpoenaed to court, my fee is $1000.00 per day as I would lose potential income.

Session Guidelines

I hold 50 minute sessions. If you need to cancel an appointment, you must give me 24 hours notice. Otherwise you will be charged for the missed appointment.

Sessions are expected to begin and end at the scheduled time. Late arrival on your part will not extend the scheduled ending time for a session. I am also expected to be on time, and I will make appropriate remedy if I am late, such as by making up the time, prorating the fee, etc.

The frequency of sessions and the length of the psychotherapy are aspects of the work that you and I will decide together as we proceed. Brief therapy is usually around 10 sessions. Some clients need additional sessions to reach their treatment goals.

Sessions can be difficult and it may seem you feel worse than when you started counseling. Give the process a chance to work. It takes time to heal and learn new ways to handle the very thing that brought you to counseling. You might be tempted to stop treatment too soon because you are not progressing as expected. If this is the case, let's talk about it. My main goal is to help you.

Outside Contact and Emergencies

You may leave a message for me on my private, confidential voice mail (682-234-5298) at any time. I check my messages daily, and I will return your call as soon as I can. However, this number is not an emergency phone number.

In case of an emergency, or if you need immediate assistance for any reason, please call 911.

Again, please feel free at any time to ask me any questions you may have about the information outlined in this or any of my other forms.

If you have a complaint, you can contact The Texas State Board of Examiners for Licensed Professional Counselors

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369 / 1-800-942-5540

___ I have seen and read the information contained in this Information, Disclosure and Consent Form.

___ I consent to treatment as described in this form.

___ I agree to the fee of 150.00 and will pay for my therapy expenses as described above.

___ Court fee is $1000.00 per day with no hourly rate.

___ I authorize the release of healthcare information necessary to process claims generated by the office of Family Counseling by Debbie McGrath.

___ I hereby authorize payment directly to Debbie McGrath, LPC of any benefits due me for counseling/psychotherapy/biofeedback.

___ I understand that I am responsible for any amount not covered by my insurance if Debbie McGrath, LPC is not in my insurance network or my insurance company does not provide coverage for services obtained.

___ I have read a copy of Confidentiality/HIPAA Practices and understand that I may request a copy for my records.

I have understood and received a copy of this agreement.

_____

Signature of Client

Date _____

Debbie McGrath, LPC

Contacting You

- Debbie McGrath may leave appointment reminders by texting this phone number
  _____
- Debbie McGrath may leave appointment reminders by sending a message to this email
  _____
- Debbie McGrath can call me at the following phone number should she need to speak with me
  _____

Informed Consent/Insurance

Insurance card with this form to be photocopied

Name of Insured: _____ SSN: _____
Insured's DOB: _____ Insurance Carrier: _____
Benefit/Eligibility Phone Number: (_____) _____ - _____

ID#: _____ Group#: _____

Deductible: _____

Address: _____ CITY: _____ ST: _____ ZIP: _____

Insured's Employer: _____

Address: _____ CITY: _____ ST: _____ ZIP: _____

I authorize the release of any medical or other information necessary to process this claim.

_____

Insured's or Authorized Person's Signature

I authorize payment of medical benefits to the provider of services. I understand that I am responsible for my bill, not my insurance company. I am aware that if my insurance company declines payment, I am responsible for my bill.

_____

Insured's or Authorized Person's Signature

682-234-5298
counselingbydebbie@gmail.com

Family Counseling

Debbie McGrath, M.Ed, LPC

www.findthecalm.net

Adult Self-Report Form

Name: _____ **Birth Date:**_____
Address _____

Chief Concern

Please describe the main difficulty that has brought you to see me:

Your medical care (From whom or where do you get your medical care?)

Clinic name:

Phone:

Doctor's name:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Your current employer

Employer:

Work phone:

Address:

Occupation:

Length of time with this employer:

Present relationships

How do you get along with your spouse or partner?

How do you get along with your children?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

When:

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When

From Whom:

For What:

Results:

List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble

career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Family:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Friendships:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Physical health:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Mood:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Sexual functioning:
1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.