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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

Debbie McGrath McGrath, LPC

Aledo UMC Annex
100 Pecan St,
Aledo, TX 76008

Ft Worth Location
3509 Hulen St, Suite 100
Ft. Worth, TX 76107

Phone 682-234-529 Fax 817-810-9585
counselingbydebbie@gmail.com

Child's Name____**DOB**___________________

Current Concerns:

What concern brings you or your child in?

When did this concern begin? (Please attempt to use dates.)

Has your family/child been in therapy before or received any prior professional assistance for your mental well-being? If so, please give dates:

What do you hope to accomplish in counseling for your child?

Please rate how much support you and your family have overall:

A Lot Some Limited Very Little None

Are there any cultural, religious, spiritual, or ethnic factors for your family that you would like me to be aware of? If yes, please describe:

What does your child enjoy doing in his or her free time, either on his/her own or with others?

What would you say are your child's strengths?

School Issues

Are you concerned about behavior at school?   If so, explain.

Are you concerned about your child's academic progress at school?

Does your child enjoy school?

Physical Health

What activities does your child engage in to stay physically healthy? (i.e., exercise, sleep, diet, meditation, etc.):

Do you have any current concerns about your child's physical health? Please specify:

Does your child you have a physical/medical health provider? If yes, what is his or her name?

Please list medicines your child is currently taking, or has taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Medication: ______________________ Dosage:_______________________ Prescribed By:______________________

Medication: ______________________ Dosage:_______________________ Prescribed By:______________________

Physical Symptoms

Check any of the following symptoms that apply to your child:

Headaches __

Stomach issues __

Skin problems __

Dizziness __

Tics __

Dry mouth __

Palpitations __

Fatigue __

Burning /itchy skin __

Muscle spasms __

Twitches __

Chest pains __

Tension __

Back pain __

Rapid heart beat __

Sexual disturbances __

Tremors __

Unable to relax __

Fainting spells __

Blackouts __

Bowel disturbances __

Use Laxatives __

Excessive sweating __

Tingling __

Watery eyes __

Visual disturbances __

Numbness __

Flushes __

Hearing problems __

Don't like being touched __

Poor appetite __

Binge/Purge __

Constipation __

Allergies __

Nausea __

Substance Use

Please share information about the substances that you know/believe your child has used within the past year. Include street drugs, misuse of prescription medication, and use of medication not prescribed.

Substance- How much and how often? When last used? Age started using

Please share information about substance use by other people living in the child's home.

Mental Health History

Has anyone in the immediate family ever been hospitalized for psychiatric reasons? If yes, please provide dates:

Has anyone in the immediate family attempted suicide? If yes, when was the most recent attempt?

Does your child do things that other people might think are impulsive, risky, or dangerous? If yes, please describe:

Does your child have a history of abuse of any kind (sexual, physical, or verbal)?

Many people have the following experiences. Please circle any of these that you believe your child experiences more than other children:

Difficulty focusing or prioritizing Irritable

Overactive/restless Nightmares
Do or say things without thinking about the consequences

Can't stop thinking about a past experience Hot temper

Anxious Bad memory
Preoccupied with body weight or shape Feel that people are conspiring against him/her
Do things that are harmful to self or others
Hear or see things that other people don't hear or see

Chronic relationship problems

Feel hopeless Difficulty telling the truth
Thinking about suicide Getting into physical fights
Weight loss/gain Stressful home conditions
Intense highs and lows with his/her mood
Experiences that he or she does not understand Can't slow down thinking
Homicidal thoughts Panicky
Overly dependent on others
Extreme fear of a specific object, activity, or situation

Lack of motivation

Going out of my way to avoid things that he or she fears

Working too hard

Worry about what others might think of him/her

Crying/tearful

Feel driven to do things over and over ¨

Eating problems (i.e., not eating, binging, etc.)

Frequent, unwanted thoughts or images

Drinking or using drugs

If there is any other information you'd like to share with me on this form that was not covered in the questions above, please take the space below to do so.

Name of individual completing this form. ____

Date _____________________