

RICHARD W. MCDILL, MA, LPC

Tax I.D. # 61-1536996 License Type: Licensed Professional Counselor License Number: 61339
1311 Chisholm Trail #301 — Round Rock, Texas — 78681
cel: (512) 964-3953 fax: (512) 248-9833
website: www.rmcdill.com email: txlpc@rmcdill.com

INTRODUCTION

This Agreement is intended to provide _____ (herein "Patient/s") with important information regarding the practices, polices and procedures of Richard W. McDill (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient.

INFOMATION ABOUT THIS PRACTICE

The individual therapist who operates this practice is: **Richard W. McDill, tax I.D. # 61-1536996**
Contact information: 1311 Chisholm Trail #301 — Round Rock, Texas — 78681
cel: (512) 964-3953 fax: (512) 248-9833
website: www.rmcdill.com email: txlpc@rmcdill.com
License Type: Licensed Professional Counselor License Number: **61339**

FEEES AND INSURANCE

The fee for service is \$_____ per 50-minute individual therapy session.
The fee for service is \$_____ per 50-minute conjoint (premarital/marital/family) therapy session.
The fee for service is \$_____ per 90-minute individual EMDR* therapy session.

Therapist is not a contracted provider with any insurance company and/or managed care organization. Should Patient choose to use his/her insurance, Therapist will provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid. Therapist will not submit for the patient any type of insurance reimbursement paperwork or file any type of insurance claim for services rendered.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

* Eye movement desensitization and reprocessing (EMDR)

CONSENT TO TREATMENT

It is important in beginning of a professional counseling relationship for you to understand both its nature and its limitations. Please review this document and feel free to ask any questions. It contains important information about our professional services, business policies, and the current legal and ethical requirements for psychologists, professional counselors, marriage and family therapists, and clinical social workers.

CLIENT RIGHTS AND THE COUNSELING AGREEMENT

also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a **Notice of Privacy Practices** (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of your first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it, or if you have not satisfied any financial obligations that you have incurred.

Your first visit will include completing necessary paperwork and meeting with the therapist, and it may include taking a personality inventory. If it appears that we can provide you with services helpful to your concerns, you will be assigned a therapist who is closely matched to your specific needs. Often this is your intake therapist; however, it is sometimes necessary to refer you to another clinician. If this occurs, your file will automatically be transferred to your regular, ongoing therapist. If for some reason I am not able to help you, your file can be transferred to an outside therapist, only with your written permission.

_____/_____**LIMITS ON CONFIDENTIALITY REGARDING “MANDATED REPORTING”**: There are some situations in which a therapist is legally obligated to take actions that he/she believes are necessary to attempt to protect others from harm, and he/she may be required to reveal some information about a client’s treatment.

- If a therapist has knowledge or reasonably suspects that a child under 18 has been the victim of child abuse or neglect, the law requires that the therapist file a report with the appropriate governmental agency, usually **Child Protective Services**. A therapist also may make a report if he/she knows or reasonably suspects that mental suffering has been inflicted upon a child or that his/her emotional well being is endangered in any other way (other than physical or sexual abuse, or neglect). Once such a report is filed, the therapist may be required to provide additional information.
- If a therapist observes or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, or if an elder or dependent adult credibly reports that he/she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, the law requires that the therapist report to the appropriate government agency, usually **Adult Protective Services**. Once such a report is filed, the therapist may be required to provide additional information.
- If a therapist has reasonable cause to believe that the client is in such mental or emotional condition as to be **dangerous to him/her**, the therapist may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

If such a situation arises, your therapist will limit disclosures to what is necessary.

_____/_____**LIMITS ON CONFIDENTIALITY REGARDING “RELEASE OF INFORMATION”**: The law protects the privacy of all communications between a client and a therapist. In most situations, your therapist can only release information about your treatment to others if you sign a written Authorization (called a Release of Information) form that meets certain legal requirements imposed by state law and/or HIPAA. However, there are some situations where your therapist is permitted or required to disclose information without either your consent or Authorization:

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, he/she will make every effort to avoid revealing the identity of clients. The other professionals are also legally bound to keep the information confidential. If you do not object, your therapist will not tell you about these consultations unless he/she feels that it is important to your work together. Your therapist will note all consultations in your Clinical Record.
- You should be aware that we employ administrative staff. In most cases, your therapist may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of our mental health professionals are bound by the same rules of confidentiality, and all staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required to collect overdue fees are discussed elsewhere in this Agreement.
- If you are involved in a court proceeding and a request is made for information about the professional services provided you and/or the records thereof, such information is protected by therapist-patient privilege law, and no information will be provided without your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and your therapist does not have grounds for objecting under

state law (or you have instructed him/her not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

- If a government agency is requesting the information for health oversight activities pursuant to their legal authority, your therapist may be required to provide it for them.
- If a client files a complaint or lawsuit against his/her therapist, relevant information may be disclosed regarding that client in order for the therapist to defend him/herself.
- If a client files a worker's compensation claim, the therapist must, upon appropriate request, disclose information relevant to the claimant's condition to the worker's compensation insurer.

An additional limit on confidentiality would be if your therapist is an intern. As such, your therapist receives supervision by a licensed therapist who supervises your counselor's caseload, and cases will be discussed in supervision. In addition, with your written permission, your therapist may audio/video tape your sessions for purposes of supervision.

_____/_____**EMERGENCIES:** If there is an emergency during your work, where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, your therapist will do whatever he/she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. Your therapist may also contact the person(s) whose name you have provided on the biographical sheet.

_____/_____**CONTACTING YOUR THERAPIST:** Your therapist will often not be immediately available by telephone; however, you may leave a message by voice-mail, which is monitored frequently. He/she will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please provide some times when you will be available. If you are unable to reach your therapist and feel that you can't wait for him/her to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your therapist will be unavailable for an extended time, he/she will provide you with the name of a colleague to contact, if necessary.

_____/_____**TELEPHONE CHARGES:** If there is a matter where you need a brief/emergency consultation with your therapist, you may telephone your therapist to reschedule or discuss something. Calls that exceed 10 minutes may result in your being charged a prorated fee proportionate to your regular fee. For a life-threatening emergency, call 9-1-1 or go to the nearest emergency room.

_____/_____**CONFIDENTIALITY OF ELECTRONIC COMMUNICATION:** E-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through their systems. And faxes can easily be sent erroneously sent to the wrong number/address. Please notify your therapist if you decide to avoid or limit in any way the use of any or all of the aforementioned communication devices. In addition, please do not use e-mail or faxes for emergencies.

_____/_____**THERAPIST'S INCAPACITY OR DEATH:** I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my files and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my files and records and provide me with copies upon request, or to deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

_____/_____**APPOINTMENTS:** Appointments are made by calling (512) 964-3953 Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. Please call to cancel or reschedule at least 24 hours in advance, or **you will be charged for the missed appointment.** Your appointment time is reserved for you. It is your responsibility to notify your therapist at least 24 hours in advance if you are unable to attend. Cancellations of appointments less than 24 hours in advance and "no shows" are subject to the full fee for the appointment time.

_____/_____**PAYMENT & FEES:** You are expected to pay for services at the time they are rendered unless other arrangements have been made. **The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges.** Services are rendered and charged to the client, not to the (or) a insurance company. Your therapist will provide you with a receipt to submit to your insurance company for reimbursement. Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records and the fee for the undersigned therapist's services will be at three times the therapist's normal hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the therapist. The therapist will require a deposit for 10 clinical clock hours for anticipated court appearances and preparation. There is a \$30.00 charge for returned checks.

_____/_____**TERMINATION OF THERAPY:** Your therapist believes that how long you remain in therapy is a matter best left in your hands. Although your therapist will certainly provide counsel for you on this matter, you must make the ultimate decision about continuing care. We hope that a decision to end counseling will be discussed candidly and thoroughly with your therapist in advance of leaving.

_____/_____**THE PROCESS OF PSYCHOLOGICAL SERVICES:** Psychotherapy has both benefits and risks. Although it has been shown to improve relationships, help provide solutions to specific problems and reduce feelings of distress, it often may create uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. There are no guarantees of what you will experience or of what benefits you might receive; however therapy will be the most successful when you take a very active part in your own treatment.

_____/_____**SPECIALTIES/ EXPERIENCE OF THE THERAPIST:** Our therapists are trained in individual psychotherapy, family therapy, relationship problems, child therapy, attention and learning disorders, and/or psychological testing. They do not prescribe medications or directly advise on medical or legal problems. Each therapist has his/her own approach, or "theoretical orientation" in working with clients. Please feel free to inquire about your therapist's approach and/or to ask about alternatives.

_____/_____**DUAL RELATIONSHIPS:** The Texas State Board of Examiners of Professional Counselors defines "dual relationships" as "any non-counseling activity initiated by either the licensee or client for the purpose of establishing a non-therapeutic relationship," and strictly prohibits said dual relationship between any licensee and client. An example of a dual relationship is for both parties to plan to meet at a book study club, or community educational class, etc. In addition, therapy never involves a sexual relationship! Lastly, not all relationships outside of therapy are considered unethical dual relationships, for example, such as attending the same community event or church. Your therapist will carefully assess before entering a therapeutic relationship with you, whether or not a particular form of contact outside of the therapy office would compromise his/her objectivity, clinical judgment and therapeutic effectiveness. If external contact with your therapist evolves after you have already begun a therapeutic relationship with him/her, your therapist may discontinue his/her involvement in said activity, if he/she finds that it is interfering with the effectiveness of your therapeutic process. Lastly, if you encounter your therapist in any public setting, he/she will never approach you or even acknowledge you unless you first initiate contact so that he/she may protect your confidentiality and the nature of your professional relationship.

_____/_____**PROFESSIONAL RECORDS:** The laws and standards of LPCs (Licensed Professional Counselors), LCSWs (Licensed Clinical Social Workers), and LMFTs (Marriage & Family Therapists) require keeping Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider) and your therapist believes that access is reasonably likely to cause substantial harm to such other person or where Forms: HIPAA consent information has been supplied to your therapist confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. There will be a copying

fee of 25 cents per page (and for certain other expenses). If your therapist refuses your request for access to your records, you have a right of review (except for information supplied to your therapist confidentially by others), which he/she will discuss with you upon request.

_____/_____**MINORS & PARENTS:** Clients under 18 years of age, who are not emancipated, can consent to psychological services subject to the involvement of their parents or guardian unless the therapist determines that their involvement would be inappropriate. A client over 12 years of age may consent to psychological services if he/she is mature enough to participate intelligently in such services, and the minor client either would present a danger of serious physical or mental harm to him/her or others, or is the alleged victim of incest or child abuse. In addition, clients over 12 years of age may consent to alcohol and drug treatment in some circumstances. However, unemancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child’s treatment records unless the therapist determines that access would have a detrimental effect on the professional relationship with the client, or to his/her physical safety or psychological well-being. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement, is also essential, it is usually our policy to request an agreement with minors (over 12 years of age) and their parents about access to information. This agreement provides that during treatment, the therapist will provide parents with only general information about the progress of the treatment, and the client’s attendance at scheduled sessions. The therapist will also provide parents with a summary of their child’s treatment when it is complete. Any other communication will require the child’s Authorization, unless the therapist believes that the child is in danger or is a danger to someone else, in which case, the therapist will notify the parents of his/her concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and try to handle any objections that he/she may have.

_____/_____**COMPLAINTS:** An individual who wishes to file a complaint against a Licensed Professional Counselor may write to: Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369 or call 1-800-942-5540

_____/_____**ACKNOWLEDGEMENT:** *By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient’s satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. Please ask your therapist to address any questions or concerns that you have about this information before you sign!*

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form described above. The Patient/s acknowledges that I/They have received a copy of this signed intake and consent form from the therapist on the date below.

Name of Patient (please print)

Name of Patient (please sign) Date: ___/___/___

Name of Patient (please print)

Name of Patient (please sign) Date: ___/___/___

Name of Therapist/Counselor (please print)

Name of Therapist/Counselor (please sign) Date: ___/___/___