Empowering Family CONNECTIONS

Feda Shawwa M.S., LPC

Informed Consent for Services

Thank you for choosing Empowering Family Connections for your counseling needs. I look forward to working with you and your family. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

Counseling Relationship
Our relationship is a professional one rather than a social one. This means that we cannot meet outside of the counseling sessions and I may not accept gifts of any kind. You will best be served if our sessions concentrate exclusively on your concerns. We may utilize email as a means of communication, but it is important to understand the parameters of this medium. I will not engage in therapy over the internet.

While benefits are expected from counseling, such benefits and particular outcomes are not guaranteed. You may experience emotional strains, feel worse during treatment, and make life changes which could be distressing. Through regular attendance and a commitment to establishing workable goals with the counselor, positive changes are likely to occur.

Qualifications
I have completed a Master of Science in Counseling and Development at the Texas Woman's University. I am currently a Licensed Professional Counselor in the state of Texas. I have experiential training in Cognitive Behavioral Therapy. I have experience working with children, adolescents and adults struggling with a variety of emotional and behavioral concerns, including, but not limited to: anxiety, depression, behavioral challenges, poor communication and conflict resolution.

Referrals
Should you or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals.

Termination
You are free to discontinue treatment at any time and agree to notify the counselor at least two weeks in advance so that effective planning for continued care can be implemented.

Records and Confidentiality
All of our communication becomes part of your clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of five years after the client's 18th birthday. All of our communication is confidential, except in the following cases:

- it is determined that you are a danger to yourself or others
- you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person
- I am ordered by court to disclose information
- you direct me to release your records
- required by law to disclose information
- In the case of billing or collection fees
- Any other exceptions authorized by law

Peer consultation is a process within the counseling profession whereby cases are reviewed with professional, objective colleagues to ensure quality counseling. It is understood that this process may be utilized with licensed professionals in order to provide the highest quality services. No names or identifying information will be used in this process to ensure confidentiality.

Confidentiality with Marriage and Couples Counseling
In the case of marriage or family counseling, I cannot guarantee confidentiality of information you disclose to me without your family member's knowledge. I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge a secret to be detrimental to the therapeutic progress.

Session Fees
Counseling sessions are 1 hour in length. You are financially responsible for treatment and agree to make payment at the time of service. You are also required to provide a 24 hour cancellation notice if unable to attend the scheduled session. A $50 fee will be charged for all cancellations without a 24hr notice.

I reserve the right to suspend services if there is an unpaid balance on your account.

Assigned Benefit
In the event that insurance is billed on your (the client) behalf, you authorize payment of mental health benefits to Feda Shawwa.

* all returned checks will incur a $30 fee

Cancellation
In the event that you will not be able to keep an appointment, please notify me by phone or email at least 24 hours in advance. A fee of $50 will be charged for any missed appointment without a 24 hr cancellation. This will need to be paid in full before the next appointment will be scheduled.

Legal Fees
My fee for court preparation and related travel is $200 per hour. If I am subpoenaed to testify regarding our counseling relationship, then I will block out half a day (unless I am notified that I will be required to stay longer) of my work day. My fee for court appearances that require the half day block is $3,000.00. If your hearing is rescheduled, it is your responsibility to notify me at least 72 hours in advance, so that I may re-book those appointments. If you fail to notify me within the appropriate time frame, you will be billed for that block of time. I require the minimum court fees ($3,000.00) 48 hours in advance of the hearing and any additional fees will be billed and are expected to be paid within 48 hours of the court appearance. You are responsible for any legal fees I incur as related to your case (litigation issues, lack of payment, etc.).

Client Rights
I assure that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time you are dissatisfied with my services, please let me know. If we are not able to resolve your concerns, you may report your complaints in writing to the Complaints Management and Investigation Section, Texas State Board of Examiners of Professional Counselors P.O. Box 141369, Austin, TX 78714-1369 or by calling 1-800-942-5540 to obtain more information.

Respect for Counseling
Any recordings (audio or visual) of the counseling session are prohibited, unless written consent is given between all parties.

Emergencies
Should you need emergency assistance after hours, you may go to the nearest hospital emergency room, call 911 or call the 24 hour Mental Health Crisis Hotline at 972-562-7722, the Suicide & Crisis Center at 214-828-1000, or the Counseling and Crisis Line at 214-233-2233. For non-emergencies, you may leave a message and I will return your call in a timely manner.

By your signature below, you are indicating that you have read and understand this statement and are consenting to entering this counseling relationship, as outlined above.

_____	_____	_____
Printed Client Name	Signature	Date
_____	_____	_____
Printed Client Name	Signature	Date
_____	_____	
Counselor Signature	Date	

I hereby state that I have the right to consent to psychiatric and psychological treatment for _____*(child's name)*
I give my permission for him/her to receive counseling services and
will provide court documentation regarding the right to consent. _____ (Parent Initial)

HIPAA COMPLIANCE

The HIPAA notice describes how mental health information about you may be used and disclosed and how you can get access to this information. This Privacy Notice tells you about your rights about your mental health care records. You can look at this copy anytime to see what use is made of your health care records and who gets to see them. A new government rule requires that we give you this Privacy Notice to sign.

The HIPAA Compliance notice is posted in the waiting room. If you would like a hard copy of the HIPAA Compliance information, please let your counselor know and a copy will be provided for you. Please review it carefully.

By signing below, you attest that you have read and have been made aware of your rights of confidentiality as a mental health consumer.

_____ _____
Client/Guardian Printed Name Relationship to Patient

_____ _____
Client/Guardian Signed Name Date Signed