



1400 Woodloch Forest Drive, Suite 575, The Woodlands, TX 77380
Office: 281-528-1523 Fax: 281-719-0491

INFORMED CONSENT & CONFIDENTIALITY

Client Name _____

Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____

Where do you prefer messages be left? _____ May we text you (SMS)? Y N

Email _____ May we email you? Y N

Emergency Contact _____ Relationship _____

Contact # _____ Do we have consent to contact your Emergency Contact: Y N

Minor's Guardian Information:

Guardian's Name (s) _____

Guardian's Relationship (circle one) Single Married Divorced Partners Separated

Guardian's Contact Information _____

Were you referred to our office by anyone? _____

OVERVIEW OF THERAPY

I welcome the opportunity to work with you! The following information will provide you with information about working with me as your therapist. Legally this is called "Informed Consent." The information contained here will help you understand better what to expect. Please review the following and feel free to ask questions regarding any items that are unclear to you.

INFORMED CONSENT

CONSENT FOR TREATMENT

I hereby seek and consent to take part in psychological treatment and authorize a therapist of LifeSpring Behavioral Health to perform initial interview, therapy and/or psychological testing with me.

I am aware that the practice of psychotherapy or counseling is not an exact science and the predictions of the effects are not precise nor guaranteed. I understand each therapist will work with me as conscientiously and diligently as they can to achieve the best possible results. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures by this office or treating counselor. I understand there are risks and benefits of receiving these services and the risks and benefits of not receiving these services for myself.

Further, I understand that evaluation and treatment will involve discussion of personal events in my and/or my family's own history which, at times, can be discomfoting and very personal. I am aware I may terminate my treatment any time without consequence. I will remain responsible for payment for services I have received.

While our sessions might be psychologically intimate, it is important to realize the therapeutic relationship is professional rather than social. Our contact will be limited to the appointments you arrange with me at the office or by telehealth. A therapist cannot attend social gatherings, accept gifts over \$50 amount, or relate to you in any way other than in the professional context of the therapy sessions. A client is best served if the relationship remains strictly professional. Patient gain is the most important part of the therapeutic relationship.

By initialing you agree to all these terms regarding Consent for Treatment: (Client Initial _____)

BILLING, APPOINTMENTS AND CANCELLATIONS

Fees:

INITIAL EVALUATION (75 minutes) \$160-\$190

INDIVIDUAL COUNSELING SESSION (45-60 minutes) \$110- \$135

GROUP THERAPY (90 MINUTES) \$40-\$50

PAYMENT

Payment is required at the time of service. The practice accepts cash, check, or Visa/MasterCard/Discover/AmEx.

There is a \$35 fee for returned checks.

LifeSpring does not file with insurance. An invoice will be provided upon request with all the appropriate information necessary for you to file for possible out-of-network benefits if you wish. Existing balances must be paid before further services will be scheduled or provided.

You will be billed 50% for missed appointments and those cancelled without 24 business hours' notice. If you are late to an appointment by more than 20 minutes it will be considered a no-show, the session will have to be paid for and rescheduled. Remembering your appointment is your responsibility. Your credit card on file will be charged if you miss the appointment.

By initialing you agree to and indicate that you understand all these terms regarding Billing, Appointments & Cancellation and Payment: (Client Initial _____)

CONFIDENTIALITY

All our work together, our conversations, our records, and any information you provide me, is protected by legal privilege. This means the laws protect you from having you or your child's information given to anyone.

Our practice respects your privacy and we intend to honor your privilege. If you choose to file with your health insurance company, they will likely require a diagnosis to justify payment. Any diagnosis made will become a part of your permanent health record.

The information you provide in therapy is confidential and will not be shared with anyone without your written consent as prescribed by law. However, there are a few circumstances when confidentiality, by law, will not be maintained, including the following:

- Concern of imminent harm to yourself (suicide) or others (homicide)
- Suspicion of child or elder abuse or neglect
- Order for release of records by a judge or district attorney
- Requirement for mental health services from disability, insurance, etc.
- Sexual exploitation by a previous mental health provider
- Any other situation required by law

If you are under 18, your legal guardian will have access to your records and ability to authorize release of the information. It is the therapist's policy to ask the parents or legal guardian (s) for privileged communication with the child unless the child has given the therapist permission to share information with the parents or legal guardian(s) or imminent danger or abuse are disclosed. When counseling a minor, the focus of therapy will be healing in the child's life and confidentiality is a key component to seeing healing come about.

In the interest of the client, the therapist may consult confidentially with other professionals regarding your information to provide the best care possible.

I, _____, give written consent to LifeSpring Behavioral Health to discuss my confidential information with the following people:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

LITIGATION LIMITATION

Texas law requires that records are maintained each time we meet or talk on the phone. These records will include a synopsis of the therapy's session, observations made by the therapist and client's treatment plan. Due to the nature of the therapeutic process and it involving making a full disclosure with regard to confidential matters, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you nor your attorney, nor anyone else acting on your behalf, will ask me to testify in court or any other proceeding, nor will a disclosure of records be requested.

CONTACT BETWEEN SESSIONS OR EMERGENCIES

For scheduling, please contact your therapist Monday through Friday and we will do our best to return calls within 24 hours or less. For emergencies, please call your local hospital emergency room or 9-1-1.

The Internet is not a totally secure medium for purposes of transmitting counselor-client or other privileged information. If you send messages by email or other electronic form of transmission, you acknowledge and agree you may be compromising confidentiality. If you do correspond with me by email or text, this indicates your consent to receive email or text back from me and therefore I can be held harmless.

COMPLAINTS

Please discuss with me any concerns or complaints you may have as soon as possible so we can work toward a resolution. Expressing anger or disappointment can strengthen our therapist-patient relationship. Ethical concerns can be reported to the following organizations:

LCDC

Texas Health and Human Services
Hhs.texas.gov
512-834-6605
PO Box 149347
Mail Code 1979
Austin, TX 78714-9347

LPC or LCSW-S

Texas Behavioral Health Executive Council
Bhec.texas.gov
800-821-3205
333 Guadalupe St
Tower 3 Room 900
Austin, TX 78701

LifeSpring Behavioral Health Therapists:

Christopher M. Crawford, MSW, LCSW-S, LCDC

Michael P. Groves, MA, NCC, LPC

Emily M. Lash, MA, NCC, LPC

Heather Loftus, MA, LPC,

Tammy E. Nix, MA, LPC-S, LCDC

Kathryn G. Wainscott, MA, LPC-Associate Supervised by Christie Farris, MA, LMFT, LPC-S

Nicole Garrett, MA, LPC-Associate Supervised by Sara Mischler, MA, LPC-S

MAXIMIZING RESULTS

1. Please arrive on time for your appointments. This helps me stay on schedule, minimizes wait time and it ensures you receive your full allotted time.
2. Success in therapy depends on your desire for change and your willingness to be honest with yourself and with me. Awareness of needs, willingness to feel and to talk about negative emotions, curiosity, and openness to direction will maximize your benefit from our counselor–client relationship.
3. I believe that complete healing requires addressing the mind, body, and spirit. Research shows that regular exercise, a healthy diet, and other lifestyle changes improve overall health and quality of life. As a Christian, I believe that prayer is an important part of healing and change. If you would like, I will pray for you at the beginning or end of a session. It will be up to you to let me know if that is your desire.

Your signature below indicates that you have read, understood, and agree to the above terms:

I request _____, provide professional services to me _____ or to _____, who is my _____. I agree this therapeutic relationship with this therapist will continue as long as the therapist provides services or until I inform the therapist that I wish to end it.

Signature of client (or person acting for client) Printed Name Date

I, _____, have discussed the issues above with the client and/or guardian. My observations of the person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist Date



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GOOD FAITH ESTIMATE - THERAPY

FOR INFORMATIONAL PURPOSES ONLY. As required by law, this is our notification to you of the possible costs of our services. No action is needed from you. If you have any questions, please contact our office.

Diagnosis: To be determined at initial evaluation

New Patient Evaluation	90791	75-105 minutes	\$160-\$215/Session
Psychotherapy	90834, 90837	45-60 minutes	\$110-\$145/Session
Psychotherapy	90832, 90840	30 minutes	\$50-\$80/Session
Family/Couples Therapy	90847	50-75 minutes	\$120-\$180/Session
Group Therapy	90853	90 minutes	\$50-\$75/Session

Dates of Service: Initial Evaluation and Regularly Scheduled Follow-ups.

Estimated Cost Per Year - \$160 - \$8000

Tax ID: 26-2875640

Tammy Nix, MA, LPC, LCDC	License #71269
Chris Crawford, MSW, LCSW-S, LCDC	License #54650, 11208
Emily Lash, MA, NCC, LPC	License #82306
Michael Groves, MA, NCC, LPC	License #84120
Kathryn Wainscott, MA, LPC-A	License #86588
Nicole Garrett, MA, LPC-A	License #87835

This Good Faith Estimate (GFE) shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The GFE does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If you are billed for more than this GFE, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the GFE. You can ask them to update the bill to match the GFE, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this GFE. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.