JANA SCHMITT COUNSELING, PLLC

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PROFESSIONAL DISCLOSURE AND INFORMED CONSENT

I am pleased you have chosen me as your counselor. This document is designed to tell you about my background, my fees, and to insure that you understand our professional relationship. Effective therapy is founded on mutual understanding and good rapport between the client and therapist. It is my intent to convey the policies and procedures used in my practice, and I will be pleased to discuss any questions or concerns you may have.

Please read and sign at the end stating you have fully read and understand the information below.

CREDENTIALS: I am a Licensed Professional Counselor (LPC). I hold a Bachelor of Science degree in Exercise Technology with a minor in psychology from Texas A&M University and a Master of Arts degree in Counseling from Dallas Baptist University. My professional experience and education have equipped me to work with a wide array of mental and emotional health concerns.

AVAILABLE SERVICES: I offer counseling services for individuals, families, couples, and small groups. A more extensive review of the types of issues I work with can be found on my website at **www.thereclaimedsoul.com**.

CLIENT/THERAPIST RELATIONSHIP: A counseling relationship between a Licensed Professional Counselor and a client is a professional relationship that exists exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Although our sessions will be very intimate psychologically, it is important for you to realize that we have a professional, rather than a personal, relationship. Our contact will be limited to the paid sessions you have with me. Please do not invite me to social gatherings, ask me to write references for you, or seek out any kind of connection with me outside of our professional counselor/client relationship. Your needs can best be served as we focus solely on therapy and avoid any type of social or business relationship.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, we will have discussions about personal issues, which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The personal exploration that takes place may lead to your decision to make changes in your life. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, specific problem solving, and greater emotional, mental and spiritual health. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling.

THERAPY PROCESS: I provide short-term counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which we will determine your concerns and, if we both agree that I can meet your therapeutic needs,

develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you, services to you may be terminated. My goal is to provide the most effective therapeutic experience available to you. If at any time you feel that we are not a good fit, please discuss this matter openly and honestly with me so that we may determine if transferring to a more suitable therapist might be an appropriate course of action.

OFFICE VISITS: In order to preserve the professional atmosphere of the counseling office and to insure that you receive the most effective therapy session possible, children should not be brought to the office.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 55 minutes long. More frequent sessions are available if determined appropriate. If you must cancel or reschedule your appointment, I ask that you call my office at (972) 832-1894 at least 24 hours in advance, whenever possible. This will free your appointment time for another client. If you do not call to cancel or reschedule at least 24 hours in advance, you will be charged for the missed appointment.

LATE ARRIVAL: If you are running late for your appointment due to unforeseen circumstances, please call to let me know you are on your way. Please be aware that sessions are often scheduled back to back, which means that your session will still end at the scheduled time. Fees will not be discounted for shortened sessions due to your late arrival. I understand that sometimes circumstances arise that are beyond our control, and in these situations I will do my best to work with you to reschedule if necessary.

FEE SCHEDULE: I see clients on a fee-for-service basis only. The client is responsible for payment in full at the time of each session. Payment may be made via personal check, cash, Visa/Mastercard. A 10% discount is offered when a block of five or more sessions is purchased and prepaid.

The regular fee schedule is as follows:

Initial Evaluation Session (1st visit) (approx. 75 minutes) $85

Regular Office Visits (55 minutes) $75

Returned check fee per check $25

SLIDING FEE SCALE PROGRAM FOR ECONOMIC HARDSHIP: I offer a sliding fee scale program for individuals and families in economic hardship so that I may still serve those in need of counseling who are unable to pay at the regular fee schedule. Additional paperwork is required to apply for economic hardship. You will need to show proof of your current financial situation to be evaluated for this program. Decisions are made on an individual basis.

INSURANCE: Many insurance plans reimburse for some portion of mental health services. Please direct questions about reimbursement amounts and timeliness to your insurance company. I am not contracted (in network, preferred provider) with any insurer. I will, upon request, provide you with receipts for counseling services that may be submitted for reimbursements. **PLEASE NOTE THAT I DO NOT COMPLETE ANY INSURANCE PAPERWORK**. Please be aware that submitting a mental health invoice for payment or reimbursement to your insurance carrier carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

EMERGENCIES: IN THE EVENT YOU THINK YOUR MENTAL HEALTH IS LIFE-THREATENING OR REQUIRES EMERGENCY ATTENTION, YOU SHOULD IMMEDIATELY CALL 911 AND/OR HAVE SOMEONE TAKE YOU TO THE NEAREST EMERGENCY ROOM.

CONFIDENTIALITY: I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you. Discussions between a Therapist and a client are confidential. No information will be released without your written consent unless mandated by law. **Possible exceptions to confidentiality include but are not limited to the following situations:** child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, please bring them to my attention so we may discuss them further.

By signing this Information and Consent Form, you are giving consent for your therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless your therapist from any departure from your right of confidentiality that may result.

CONFIDENTIALITY OF E-MAIL, CELL PHONE & OTHER MEANS OF ELECTRONIC COMMUNICATION: Please be aware that e-mail, cell phone and other forms of electronic communication can be accessed relatively easily by unauthorized people; therefore the privacy and confidentiality of such communication can be compromised. Please notify me **in writing** prior to beginning treatment if you wish to avoid or limit in any way the use of any or all of the above-mentioned means of communication. **Please do not use e-mails or texting for emergencies.**

CONSENT FOR BIBLICAL-SPIRITUAL PRACTICES IN COUNSELING: Within the context of Christian counseling, certain spiritual interventions and practices are commonly integrated into the therapy session. These may include prayer during the session, Bible reading or reference, or assistance with spiritual formation and discipline. However, I do not presume that all of my clients will desire or be receptive to these practices. I desire to honor your personal choice and to create a safe space where you are free to ask questions, express doubt or confusion, explore answers and grow at your own pace.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, **should there be legal proceedings (such as, but not limited to divorce/custody disputes, work injuries, lawsuits, etc.) neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.**

TERMINATION OF THERAPY: As the client, you are in complete control and may end our counseling relationship at any point. I will be supportive of your decision, although I do request that you participate in a termination session.

INCAPACITY OR DEATH: If therapy is terminated due to my (the Therapist's) incapacitation or death, it will be your choice whether to terminate therapy or transfer to another therapist. Your signature on this form gives your consent to release your records to another therapist of your choosing.

DUTY TO WARN/DUTY TO PROTECT: As a licensed professional counselor, I have a legal and ethical duty to warn/duty to protect if I believe that you (or your child, if your child is the

client) are a physical or emotional danger to yourself or another human being. Your signature on this form gives your consent that allows me to warn the person in danger and to contact your spouse, parent, emergency contact on your Information form, or any person who is in a position to prevent harm to you or another. Your signature also expresses your consent to allow me to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name: _____

Phone: _____

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

_____
_____

Signature – Client/Parent Date

_____
_____

Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

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Client/Parent Date