**Optimal Solutions Counseling & Case Management**

**Intake and Informed Consent- Family Therapy**

Family Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: \_\_\_\_\_ Caucasian \_\_\_\_ Black American \_\_\_\_ Hispanic \_\_\_\_\_ Native American

\_\_\_\_ Asian Pacific \_\_\_\_\_\_\_ Mixed Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you want to be contacted: \_\_\_\_**phone call \_\_\_\_email \_\_\_\_text cell**

Leave voicemail on cell? (circle one) Y or N Can I text message cell an appointment reminder? (circle one) Y or N

Family Members Names:

Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where does the child live?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where does the child live?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are other children please write them on the back of this form.

Has anyone in the family had therapy before? If so, who & when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

Who in the immediate family had had a previous mental health diagnosis (bipolar, depression, schizophrenia, anxiety) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who in the family has substance abuse or alcohol use problems? If anyone, have they been treated in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in the family have current legal problems? Y or N

As a family, or as individuals do you practice a particular faith? If so, what is it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We found Optimal Solutions through (a friend/family, professional health care provider, Google search, Psychology Today)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like an emergency contact on file? If so:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address & Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By giving an emergency contact and signing below I give permission to Terri Parker, LCSW, LCDC to contact person listed in the event of an emergency.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main reasons for which you are seeking therapy:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to accomplish in therapy? 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

Many families come to therapy with many fears, anger, and repressed emotions that will be explored during our time together. Betterment of family relationships is paramount as the family of origin is the most important, and intricate of relationships we as humans have.

**What to expect from therapy:**

Our collaborative efforts during our time together will offer you insight, personal growth, and skills related to the issues that have brought you to therapy.

**Some things you should be aware of as we begin:**

We use Cognitive Behavioral Therapy (CBT) and Family Systems Theory in combination with other modalities of therapy that may fit your learning and communication style, as well as your presenting problem.

During sessions you may experience intense emotions and feelings as issues are “unpacked” and discussed. Please be assured this is a normal response and necessary for growth and movement forward as a healthy family unit.

The therapist will support the clients with the highest regard and work together through the emotions, processing them, and help with healing.

**Confidentiality**

It is my duty to protect your privacy. I will not disclose your record of therapy to anyone without your written consent, nor will I tell anyone that you are a client of Optimal Solutions.

**There are exceptions to this confidentiality agreement:**

If we have cause to believe that you are in imminent danger of harming yourself or others, we must inform the authorities. This could be a call to 911 and/or a mental health crisis team to meet you where you are, to assess your needs, and assist you with the crisis.

If we have cause to believe you are seriously planning to commit suicide and/or homicide, we must call 911 and alert the authorities of your plans and the nature of our therapeutic relationship.

If you disclose that a child, an elderly person, or disabled individual is being/ or was being abused, we are under obligation to report the disclosure to the Texas Department of Family Protective Services (CPS or APS). We are obligated by law to make a report involving children, the elderly, and people with disabilities.

**Optimal Solutions Counseling & Case Management**

**Confidentiality (cont)**

If a judge subpoenas your record, we are obligated to comply. I will inform you immediately if this occurs.

**Electronic Communication**

Your therapist will respond to emails when available. Please be aware our email optimalsolutionscounseling.com NOT secure. It is a Google email account.

Optimal Solutions Counseling & Case Management **cannot** ensure confidentiality

Of any correspondence sent via email and **cannot** be responsible for breaches in confidentiality resulting from someone obtaining your password or having access to your email account. Therefore, email communication should be reserved for scheduling and/or canceling appointments. If email content from you contains more than scheduling information, your therapist will contact you be phone to discuss your concerns. And assist you, when able. These telephone conversations will be charged at the phone rate discussed in this document. Additionally, **all email correspondence between you and your therapist will be printed and placed in your file.** Your therapist will attempt to respond within 24 hours or one business day.

**Fees**

Accepted forms of payment are cash, credit or debit. You must have a credit/debit card on file to be a client of Optimal Solutions. Payment is due at time of service.

Your initial family session in which you undergo a clinical assessment is $150 and $125 for regular family sessions. These initial sessions can range from 50 minutes to one hour.

The assessment will help us all understand any clinical presentation (diagnoses) of a family member, and will assist us in focusing on the problem identification, goals and objectives, and later the outcomes of our time together.

For subsequent visits of 50 minute sessions: the fee is $125 for family sessions to be paid at the beginning or end of each session.

**Insurance**

At this time, insurance is not being taken, however, the therapist will provide you with a “Superbill” so that you may file with your insurance.

When the therapist becomes paneled with insurances, you will be informed immediately. Expectations are of taking BCBSTX, Magellan, and United Health in the near future.

**Optimal Solutions Counseling & Case Management**

**Emergency**

Optimal Solutions **does not** provide emergency services. If you experience an emergent situation, call **911** immediately or go to the nearest emergency room for immediate care. Please be sure to inform your therapist if such a situation occurs, as soon as possible once your safety has been insured.

**Phone Calls**

Calls initiated by you between sessions that require psychotherapeutic consultation over 5 minutes will be prorated per 15 minute increments at the following costs: $25 per15 minutes to be paid at the time of the call by debit card on file.

**Text Messaging**

Feel free to contact your therapist via text message at **940.435.1927**. This form of communication **cannot** ensure confidentiality and should be reserved for scheduling and/or canceling appointments.

**Court Appearance**

If you are currently involved or become involved with any legal proceedings, please inform your therapist as soon as possible. It is important that we discuss how the proceedings might impact our work together. If legal actions occur, **even if the subpoena is sent from the opposing side of the case,** you will be responsible to the therapist for (a) time spent traveling to and from court at the rate of $150/hour with a 4-hour minimum and a $50 per day per diem. If travel over 30 miles is required, mileage charges will be added at the rate of $.50/mile, (b) time spent on preparing testimony, reports, witness time, and depositions at the rate of $150/hour with a 4 hour minimum, (c) time spent on mediations and court appearances are billed at $300 per half-day and $600/per full day. **All fees must be paid in full prior to any work being done on the legal case.**

A fee of $25 for paper copies of progress notes to the judge is also charged to you. Minimum payment for this service is expected at least one week PRIOR to the scheduled court date. We do not give refunds or credits.

**Optimal Solutions Counseling & Case Management**

**Your Records**

After each session, notes are recorded, related to what was discussed; insights, progress made, and plans to move forward toward mutual goals.  **Unless the court subpoenas the therapist,** this record will not be released without your written consent.

If the court subpoenas the therapist, you will be informed and we will work together to be in compliance with the court. The judge will be asked to respect the therapist-client privilege, however we can make no guarantee that the judge will agree.

You have the right to request in writing your records if you wish to see them. A copy will be made at a cost to you of $5 per page. The therapist and the client will then review them together so client may understand what is written and why. The therapist would rather the client inquire as to what they may be looking for in the records and discuss openly instead of requesting records.

**Cancelations**

We respectfully request 24 hours advanced notice of your need to cancel a scheduled appointment. Notice of cancelation less than 24 hours will result in your being charged for the full amount of the missed session- $125 for family sessions. If an initial assessment is missed, the initial assessment fee will be charged.

**You will not be charged the cancelation fee within these exceptions**: Denton- ISD closes school due to snowy or icy road conditions; an illness that requires hospitalization; an illness with accompanied fever, death of an immediate family member; We are able to fill your appointment time slot with another client; you reschedule within the same week and attend that session.

Finally, it is important that you make your appointments a priority, be willing to come to session with an open mind, take responsibility for getting well, and give us honest feedback. In return, we will do everything we can to ensure you get the most out of your therapy sessions.

**Optimal Solutions Counseling & Case Management**

**Incapacity or Death**

I understand that, in the event of the death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to either treat me or provide me with an appropriate referral of another licensed mental health professional, if you so choose.

By signing below, you are indicating that you have read and understand this document and agree to its terms.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

**ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE**

If you wish, you may pay fees electronically – through funds transfer or using a payment card on billing software.

Please Be Aware of the Following: We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible. After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name, and would indicate that you have paid for a therapy session. It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. We are unable to control this in many cases, and we may not be able to control which email address or phone number your receipt is sent to. So, before using one of the above services to pay for your session(s), please think about these questions:

• At which email address or phone numbers have I received these kinds of receipts before?

• Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.

• Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

• Is it better for me to pay cash to avoid these risks all together?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to Optimal Solutions Counseling & Case Management. Please consider who might have access to your statements before making payments by credit or debit card.

I have read, understand, and agree with the above risks of paying electronically and know I have the option of paying by cash or check.

Client or Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

**Notice of Risk**

Consent to Communicate Electronically Communication between sessions is sometimes necessary. The most secure way to communicate so that your confidentiality is protected is by way of phone calls. Text messaging is the next most secure way of communication as the cell phone is password protected and the message goes directly to your phone.

The least secure way of communicating with us is through email. Our email is a regular email account, which means it is no more secure than Google or Yahoo. The risk of destroyed privacy is high when using email. Email sent between us could be hacked, intercepted, and dispersed to others.

By signing below, you indicate that you have read, understand, and agree with the above notice of risk. By initialing by your preference(s), you indicate the method of contact for which you give permission.

My therapist has: (initial by preference(s))

\_\_\_\_\_\_\_\_\_\_ Permission to call my cell.

\_\_\_\_\_\_\_\_\_\_ Permission to leave voicemail.

\_\_\_\_\_\_\_\_\_\_ Permission to respond to email from me.

\_\_\_\_\_\_\_\_\_\_ Permission to contact me via text.

\_\_\_\_\_\_\_\_\_\_ Permission to contact me via email.

\_\_\_\_\_\_\_\_\_\_ Do not contact me by any of the above means except by phone call.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

THIS FORM WILL NOT BE FILLED OUT UNTIL THERAPIST BEGINS ACCEPTING INSURANCE

**Notice of Insurance Risk**

Please be aware that when using insurance to pay for sessions, insurance companies sometimes request your psychotherapy file. Information they collect includes times/dates of your session, length of session, symptoms, diagnosis and treatment plan, general discussion points, progress and plan going forward. This is standard procedure and is used, normally, for determining how many more sessions they will continue to pay. We are obligated to comply in the event of a request to view your file.

If you would rather not risk the chance of insurance requesting your file, please refer to my private pay fees in this document.

I have been informed, understand, and agree to continue using insurance for my sessions. \_\_\_\_(initial)

I have been informed, understand, and no longer wish to use my insurance for my sessions. \_\_\_\_\_(initial)

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

**Credit Card Consent**

**The below credit card information, provided by the client or parent/guardian, will be placed on file. By signing this agreement you are consenting to allow Optimal Solutions Counseling & Case Management to charge below listed credit card for any cancelations, phone charges, letter and documentation fees, requested medical record fees, or court fees.**

Type of Credit Card (circle): VISA MASTERCARD DISCOVER PAYPAL

Name (as printed on credit card)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Account Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3-4 Digit Security Code/CVC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address for Credit Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By my signature below, I also request and provide Optimal Solutions Counseling & Case Management my permission to charge the above listed account for ongoing regular therapy sessions according to the fee schedule described in this document.

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Cardholder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

**Consent for Treatment**

By signing these forms as the client or the 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 ask any questions and request clarification for any issue 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. **NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of the said child, or impacting your rights with respect to consent to the child’s mental health care and treatment. Optimal Solutions Counseling & Case Management will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.**

By signing below, you are indicating that you have read and understand this document and agree to its terms.

Name of Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a child is a minor of age 11 or older and attending the first session:

Name of Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

**ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE**

If you wish, you may pay fees electronically – through funds transfer or using a payment card on billing software.

Please Be Aware of the Following: We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible. After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name, and would indicate that you have paid for a therapy session. It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. We are unable to control this in many cases, and we may not be able to control which email address or phone number your receipt is sent to. So, before using one of the above services to pay for your session(s), please think about these questions:

• At which email address or phone numbers have I received these kinds of receipts before?

• Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.

• Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

• Is it better for me to pay cash to avoid these risks all together?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to Optimal Solutions Counseling & Case Management. Please consider who might have access to your statements before making payments by credit or debit card.

I have read, understand, and agree with the above risks of paying electronically and know I have the option of paying by cash or check.

Client or Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

**Notice of Risk**

Consent to Communicate Electronically Communication between sessions is sometimes necessary. The most secure way to communicate so that your confidentiality is protected is by way of phone calls. Text messaging is the next most secure way of communication as the cell phone is password protected and the message goes directly to your phone.

The least secure way of communicating with us is through email. Our email is a regular email account, which means it is no more secure than Google or Yahoo. The risk of destroyed privacy is high when using email. Email sent between us could be hacked, intercepted, and dispersed to others.

By signing below, you indicate that you have read, understand, and agree with the above notice of risk. By initialing by your preference(s), you indicate the method of contact for which you give permission.

My therapist has: (initial by preference(s))

\_\_\_\_\_\_\_\_\_\_ Permission to call my cell.

\_\_\_\_\_\_\_\_\_\_ Permission to leave voicemail.

\_\_\_\_\_\_\_\_\_\_ Permission to respond to email from me.

\_\_\_\_\_\_\_\_\_\_ Permission to contact me via text.

\_\_\_\_\_\_\_\_\_\_ Permission to contact me via email.

\_\_\_\_\_\_\_\_\_\_ Do not contact me by any of the above means except by phone call.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

THIS FORM WILL NOT BE FILLED OUT UNTIL THERAPIST BEGINS ACCEPTING INSURANCE

**Notice of Insurance Risk**

Please be aware that when using insurance to pay for sessions, insurance companies sometimes request your psychotherapy file. Information they collect includes times/dates of your session, length of session, symptoms, diagnosis and treatment plan, general discussion points, progress and plan going forward. This is standard procedure and is used, normally, for determining how many more sessions they will continue to pay. We are obligated to comply in the event of a request to view your file.

If you would rather not risk the chance of insurance requesting your file, please refer to my private pay fees in this document.

I have been informed, understand, and agree to continue using insurance for my sessions. \_\_\_\_(initial)

I have been informed, understand, and no longer wish to use my insurance for my sessions. \_\_\_\_\_(initial)

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Optimal Solutions Counseling & Case Management**

**Credit Card Consent**

**The below credit card information, provided by the client or parent/guardian, will be placed on file. By signing this agreement you are consenting to allow Optimal Solutions Counseling & Case Management to charge below listed credit card for any cancelations, phone charges, letter and documentation fees, requested medical record fees, or court fees.**

Type of Credit Card (circle): VISA MASTERCARD DISCOVER PAYPAL

Name (as printed on credit card)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Account Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3-4 Digit Security Code/CVC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address for Credit Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By my signature below, I also request and provide Optimal Solutions Counseling & Case Management my permission to charge the above listed account for ongoing regular therapy sessions according to the fee schedule described in this document.

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Cardholder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_

Optimal Solutions Counseling & Case Management

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