# Kingdom Élan, LLC

## Client Informed Consent and Information

Please read, provide information as requested and initial at the bottom of each page. This agreement is intended to provide you, the client, with important information regarding my professional services and business policies, as well as provide a clear framework for our therapeutic relationship.

**Bio**

I earned a Master of Arts in Counseling at Dallas Baptist University in Dallas, TX in 2014. I am a Licensed Professional Counselor (LPC), Licensed in the State of Texas # 78454. I enjoy working with adults who may be experiencing lifestyle changes such as: grief and loss issues, trauma, as well as work-related issues, relationship issues, and various mental health issues such as Anxiety, Depression, Bipolar Disorder, Post Traumatic Stress Disorder (PTSD), Schizophrenia, and Schizoaffective Disorder. I also have experience working with teenagers and young adults with various life-changing situations, such as: anger, stress-related issues, behavioral problems, or other situational issues. I would love to work with older adults who may be having issues related to retirement, or other transitional lifestyle changes. My personal, educational and work-related experience has prepared me to work with individuals as young as 15 years old, all the way up to adults who are in retirement age.

**Nature of Counseling**

Counseling is the application of mental health principals, through cognitive, affective, behavioral or systemic interventions, that addresses areas such as personal growth and mental health disorders. In order to maximize your benefit from counseling, it is necessary to make a commitment to the process. In addition to talking with me at the time of your appointment, "homework" may be assigned to allow practice of new skills and behaviors. I expect that clients will be open and cooperative in the counseling process while realizing that they have a choice in the treatment plan, which can be reevaluated at any point during our therapeutic relationship.

**Risks of Counseling**

The goal of counseling is to increase self-awareness which can sometimes result in increased levels of sadness, fear, anger and related emotions that can be quite overwhelming. You may also learn things about yourself and your relationships that you do not like. Oftentimes, personal relationships are impacted by the new choices you make as a result of these new insights. Success in counseling depends on efforts made by all parties involved in the therapeutic relationship, and you are encouraged to address any goals and expectations that you feel are not being met. At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed.

**Appointments**

_____ (please initial indicating your understanding & agreement)

Appointments are made by calling the office phone 512-766-0788 Monday through Friday between the hours of 8:00 AM to 6:00 PM. Please leave a message, as we do not answer the office phones during sessions. Appointment times can also be requested through the secure Client Portal. Counseling sessions are 50 minute sessions. I happily accept cash, check, or credit card. At this time, I do not accept insurance payments. The number of sessions needed depends on many factors and will be discussed by the counselor. Also, please keep in mind that if you are more than 15 minutes late for your appointment, this is considered a no show and you will be charged a no show fee of $50 for the session (see below), which must be paid in full before another appointment will be scheduled.

**Cancellations/No Shows**

Cancellations should be made as soon as possible, preferably 24 hours in advance. You are responsible for calling to cancel or reschedule your appointment. A no show is when the client does not call to cancel and does not show up for the scheduled appointment. In the event that a client does not call, text or email to cancel an appointment, the client will be charged $50 for the session. Please provide credit card information below, which will ONLY be charged in the event that you no show for your appointment.

I agree to provide the following credit card information and agree to the $50.00 charge if I no show for a scheduled appointment.

_____ Credit Card Number

_____ Expiration Date Month and Year

_____ 3 Digit Code on Back of Card

_____ Zip Code for Card Billing Address

One no show will result in future sessions being taken off the schedule. It will then be the client's responsibility to contact the office to schedule future appointments. Any outstanding no show fees must be paid in full before future appointments will be scheduled. I understand things happen that can be out of our control. However, regular attendance is recommended to ensure continuity and to enhance the effectiveness of therapy. Chronic no shows will result in termination of the therapeutic relationship at the counselor's discretion.

**Telehealth/Virtual Counseling**

I am currently operating a 100% virtual counseling service. This means all forms, notes, scheduling, billing and counseling are done electronically and virtually. I use Therapynotes, a digital software, which provides the best practice management and medical records solution for my practice. Therapy notes, uses a HIPPA compliant platform to ensure privacy is maintained. Scheduling and rescheduling appointments should be done by calling the office at 512-766-0788 or using the secure online Client Portal. Due to confidentiality issues, I cannot accept friend requests on any type of social media during the course of a client's treatment.

The scheduling software will contact you via email to confirm your appointment. Please review the permissions for your preference to be contacted.

_____ (please initial indicating your understanding & agreement)

Phone # for contact:_____

____ Call OK ____Text OK ____Voicemail OK ____ Email OK

Email Address(es): _____

____ I would like an email invitation to the Client Portal.

**Telephone Accessibility**

I monitor voice mail messages left at 512-766-0788 during business hours and will make every effort to return your call within 24 hours of when you make it. If you are difficult to reach, please leave the times when you will be available. Should you have a true clinical emergency after hours or any time that requires immediate attention or action, you will need to call 911 or go to the nearest emergency room. The phone number listed above should NOT be used as a crisis hotline and I am not available 24 hours a day.

**Professional Fees and Payments**

Self-pay fees are $100 per 50 minute session. Cash, credit cards and personal checks are accepted. I do not keep change in the office, so please have the exact amount or plan to apply the overage to your next bill. Checks must be made out to Kingdom Élan, LLC or Jennifer Frazier. You will be provided with an electronic receipt each session upon request. Failure to pay for services rendered will be addressed in session and if no financial arrangement can be made, termination will be necessary. In general, it is important to discuss with me any issues that arise in connection with our financial arrangements, so that they do not hinder our working relationship. I do not charge for telephone consultations less than 15 minutes. Consultations of greater length may be prorated based on your hourly $100.00 session fee. In the event that I am subpoenaed, there is a one-time $500 charge for my time spent preparing for and testifying in court.

**Confidentiality/Notice of Privacy Practices**

The names of clients that you may have contact with at this office are to be kept confidential and are protected by Texas Laws relation to Mental Health Mental Retardation (Article 5561H, see 2a and 2b). As a client/parent at this office, understand that you must comply with this policy regarding confidentiality. Please also understand that this applies to all visits from this date forward.

Discussions between counselor and a client are confidential. No information will be released without the client's 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 an issue; situations where the counselor has a duty to disclose, or where, in the counselor's judgment, it is necessary to warn, notify, or disclose; fee disputes between the counselor and the client; a negligence suit brought by the client against the counselor; or the filing of a complaint with the licensing board or other state or federal regulatory authority. If you have any questions regarding confidentiality, you should bring them to the attention of the counselor when you and the counselor can discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned counselor to share

_____ (please initial indicating your understanding & agreement)

confidential information with all persons mandated by law and/or with the agency that referred you and you are also releasing and holding harmless the undersigned counselor from any departure from your right to confidentiality that may result.

In the case of adolescent or family counseling, I will keep confidential (within the limits cited above) anything that you/child disclose to me without the family members' knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the relationship to be detrimental to the therapeutic process.

**Authorization to Release Information**

I/We _____ (name of client or guardian) hereby authorize Jennifer Frazier, MA, LPC to release records and/or information concerning treatment dates and diagnosis to:

_____

(Name of Referral Source, Spouse, etc.)

**Duty to Warn**

In the event that the undersigned therapist reasonably believes that you are in danger, physically or emotionally, to yourself or another person, you specifically consent for the counselor to warn the person in danger and to contact any person to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the person you have identified as your Emergency Contact. This information is to be provided at my request for use only to prevent harm to myself or another person. This authorization shall expire upon the termination of counseling.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned counselor has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law.

Emergency Contact Name: _____ Phone # _____

**Counselor's Incapacity or Death**

I acknowledge that, in the event the undersigned counselor becomes incapacitated or dies, it will become necessary for another counselor to take possession of client files and records. By signing this information and consent form, I give my consent to allow another licensed mental health professional of my choice to take possession of my files and records and provide me with copies upon my request.

**Client Grievance Policy**

If a client becomes dissatisfied with the services provided by the counselor, the client has the right to discuss this with the counselor, then to appeal the grievance with the Texas State Board of Examiners of Professional Counselors. Great effort will be taken to mutually resolve client grievances on this level and in a timely manner. The counselor's hope is that client concerns do not lead to disruption in services. The request for appeal to the Texas State Board of Examiners of Professional Counselors must be in writing, with such a request including a brief statement of the grievance.

_____ (please initial indicating your understanding & agreement)

Anyone wishing to file a complaint with the Licensing Board against a Licensed Professional Counselor may write to:

Texas State Board of Examiners of Professional Counselors
Attn: Enforcement Division
333 Guadalupe St. Ste. 3-900
Austin, Texas 78701

**Consent for Services**

Thank you for reviewing this information and please feel free to discuss any of this information with me. This Client Informed Consent and Information will be updated January 1st of each year for all existing clients and supersedes any Client Informed Consent and Information forms signed previously.

My/our signature(s) on this disclosure statement indicates that I/we have read and understood the conditions of the counseling services outlined. I/we have had the opportunity to clarify any questions and agree to the terms described above before receiving services.

Client's Written Name(s):

_____

Date(s) of Birth:

_____

Address:

_____

Client Signature

_____ Date:_____

Guardian Signature

_____ Date:_____

Counselor Signature

_____ Date:_____