

Laura Atterstrom M.A.

Licensed Professional Counselor and Licensed Marriage and Family Therapist
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Patient/Client Information & Consent to Treat

Welcome to my practice. I look forward to working with you regarding the concerns that brought you here, and I intend for you find our work together beneficial. Please read carefully the following information concerning my professional services and business policies and discuss with me any questions you may have. Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with treatment.

QUALIFICATIONS: I am glad you are here, and I am committed to providing you with quality care. This document is designed to inform you about my background and provide information regarding our working relationship. I have been a Licensed Professional Counselor since 1990, and a Licensed Marriage and Family therapist since 1992. My Bachelor of Arts degree is from University of North Texas in Denton, Texas, where I majored in psychology. I hold a Master of Arts in Counseling from St. Mary's University in San Antonio, Texas. The counseling program was fully accredited by the National Association for Marriage and Family Therapists. I have owned and operated a private counseling practice for over 28 years providing services to adults, couples, adolescents and families.

MENTAL HEALTH SERVICES: While it may not be easy to seek help from a mental health professional, the goal in counseling is to increase your self-awareness so that you will be better able to understand your situation and feelings and move towards resolving your difficulties. Counseling is collaborative, in order to maximize the effectiveness of the process you will need to take an active role in working toward your goals both during our sessions and between sessions. In discussing your situation, you may experience difficult feelings such as anger, sadness, or disappointment. As a result, sometimes clients express that they feel worse before they feel better. However, research identifies the benefits of counseling which include symptom relief, improved communication, more satisfying relationship and a more positive perspective. I will help you to identify choices to deal with your situation that you might not have identified on your own. It will be important for you to explore your feelings and thoughts and to try new approaches for change to occur. I am trained in a variety of approaches to therapy, including cognitive-behavioral, family systems, solution-oriented, and short-term therapy. My overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, relationally, and spiritually. You may bring other family members to a therapy session if you feel it would be helpful or I may recommend that other family members attend.

SCOPE OF SERVICES: You are engaging Laura Atterstrom M.A. to provide you only with psychological, individual, marriage, or family counseling; no other services will be rendered. I do not prescribe prescription drugs; if you have any questions regarding your medications, please consult your attending physician. I do not provide emergency counseling services. Our relationship is of a professional nature rather than social, and you have my commitment to help you reach the goals that we will determine jointly. As these goals are met, we will openly discuss and reassess the need for continued counseling. While I will exert my best professional efforts in counseling and assessment, no guarantee or representation has been made nor can be made as to the outcome of the matters referred to me, nor of the date of completion. Comments about the outcome of your matter, if any, are expressions of the opinion only.

INITIAL EVALUATION, TREATMENT, TERMINATION:

Some individuals only need a few sessions to achieve their goals; others may require months or even longer. The first several sessions will involve an assessment of your counseling needs and goals. As a result, there are several possible outcomes. You and I decide that working together is beneficial for you and we continue with therapy. If you or I do not think that I am the best fit for your needs, then I am happy to provide referrals. Since therapy involves a large commitment of energy, time and money it is important to be thoughtful about the counselor you choose. I will then offer you some initial impressions of what our work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with me are crucial to your success in therapy. You have the right to discontinue our professional relationship at any time, though I recommend a termination session for reaching closure. You also have the right to refuse any recommendations I make. If your refusal, in my professional opinion, compromises my ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), I may determine to discontinue treatment. In such cases, I will provide you with referrals to other competent mental health professionals, if you desire.

COMPLAINTS:

My services will be rendered in a professional manner consistent with the legal and ethical standards established by the licensing board for licensed professional counselors and licensed marriage and family therapists. If at any time or for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns to your satisfaction, you may report your complaints to the Texas State Board of Examiners of Professional Counselors 1100 West 49th street Austin TX 78756 (512)834-6658 and /or the Texas State Board of Examiners of Marriage and Family Therapists (same address) (512) 834-6657. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the US Department of Health and Human Services, Office for Civil Rights, at OCRMMail@hhs.gov.

FEES AND APPOINTMENTS: **The initial evaluation session is billed at \$260.00 for 85 minutes and \$170.00 for 50-min. sessions thereafter. Full payment is expected at the time of service. I accept cash or checks only. I do not accept credit/debit cards.**

I do not barter or trade services or accept gifts for payment. Checks should be made payable to Laura Atterstrom M.A. Checks returned for non-sufficient funds are subject to a service fee of \$25.00. I may collect returned checks, service charges and other applicable charges. Past due amounts accrue interest at 10% per month. If the need arises, you need to agree to pay for all costs of collection, including and without limitation, any applicable attorney fees. Rates are subject to change at the sole discretion of Laura Atterstrom, with notification provided in advance of your next session. I will make every effort to begin your sessions promptly. If you are late to an appointment, we cannot extend the session time without prior arrangement.

I am not an in-network provider for any insurance plans. If you wish to use your out-of-network benefits, you will be provided a receipt so that you can file for insurance reimbursement. I do not file any insurance. Insurance benefits usually cover only “medically necessary” treatment, requiring a mental health diagnosis. Any diagnosis made will become part of your permanent insurance records and may have implications concerning future applications for life insurance or future coverage in the event of a change in health care plans. If you have concerns regarding your diagnosis, please discuss these with me.

Other services for which additional fees apply that are not covered by insurance include: telephone calls longer than 10 min, clinical consultations with other providers that you give consent for me to speak with; preparation of treatment summaries or treatment plans; letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies.

FEES FOR COURT-RELATED SERVICES:

I understand that these terms are applicable both while I am receiving services and following termination.

Phone consultations with Attorneys, Judges, Family Court Counselors, District Attorneys: \$250.00 per hour, quarter hour minimum charge.

Reports for Court, Attorneys: \$250 per hour.

Court Deposition Appearance or Court Appearance: \$250 per hour for time spent in route and on-site; 4 hour minimum charge (must be paid in advance).

Additional Out of Town Charges: Reimbursement of actual out-of-pocket travel expenses to include mileage and/or transportation cost, tolls and parking fees, meals and lodging.

Copies of Client File: \$50 minimum charge (must be paid in advance).

OTHER COURT RELATED REQUIREMENTS:

Release: Patients must sign a Release of Information form allowing Laura Atterstrom M.A. to openly communicate with all parties related to the lawsuit. For the safety and professionalism of the counseling process, no exceptions will be given.

Subpoena: A subpoena must be issued before Laura Atterstrom M.A. can make a court appearance, deposition appearance, or deliver records. Party issuing subpoena will be financially responsible for all related fees (see above charges).

Payment of Fees: All fees for records, court and deposition appearances must be paid in advance. A half day (4 hour) minimum must be paid for court appearances and/or deposition appearances.

CANCELLATION POLICY: If you provide 24 hours advance notice appointment cancellation, I will be happy to reschedule the appointment and you will not be charged the standard session fee. Any missed appointments or appointments cancelled within 24 hours of the scheduled appointment will result in you being charged the full session fee. Fees for late cancellations/missed appointments must be paid for prior to additional services being provided and are not covered by Third Party Payment Plans.

THIRD-PARTY-PAYERS/INSURANCE: Full or partial payment for services may be covered by your employer, a government agency or your insurance company (collectively a “Third Party Payment Plan”). If such is the case, the Third-Party Payment Plan may restrict or limit the type and duration of services I can provide. **Patients are expected to pay the total fee for each appointment at the time of the appointment, regardless of the terms of the Third-Party Payment Plan.** Please consult your Third-Party Payment Plan for the terms of your eligibility, your benefits and reimbursement procedures as we cannot do this for you. At your first appointment, arrangements can be made for us to provide you with documentation for you to file with your Third-Party Payment Plan. Please be advised that your Third-Party Payment Plan may send payments to me by mistake. If I do receive payment from your insurance company for fees that you have already paid, and you have no other outstanding charges to offset the payment, I will document the payment as appropriate and issue a check to you for the same amount as the payment received from the insurance provider. Your Third-Party Payment Plan will be responsible for notifying you regarding who they have paid. I am not responsible for any non-payment or any misdirected payments by your Third-Party Payment Plan.

PRIVACY NOTICES: Laura Atterstrom M.A. takes precautions to respect the confidentiality of all patients. If at any time when you are in our office you recognize someone, I ask you to respect their confidentiality as they have been asked to respect yours. Adult records may legally be disposed of seven years after the file is closed. Records for minors may be disposed of seven years after the child’s 18th birthday. I collect your non-public information about you and, with your authorization, from third parties such as your parents, guardians and other family members, attending physicians and other advisors, school, third party payers, government authorities and other advisors. I do not disclose any non-public personal information about any current or former patients to anyone except as permitted by law, or as authorized by you. You must authorize Laura Atterstrom M.A. to release/exchange your confidential information to (i) your parent, guardian and other family members; (ii) other professionals, including your attending physician and other advisors; (iii) to others if required to disclose pursuant to a subpoena, law, regulation, a court or government agency; (iv) to a third party payer if your therapist believes, at their sole discretion, that harm may/has come to you or others; or, (v) to a third party payer if that party is paying Laura Atterstrom M.A. or reimbursing you for our services; and (vi) other employees of our firm who need to know the information in order for us to work with you. I maintain commercially reasonable physical, electronic, and procedural safeguards that comply with professional standards to guard your non-public personal information.

You should be aware of the following exceptions to confidentiality:

1. You provide consent to release your records or to share information regarding your treatment.
2. You are at risk of imminent serious harm to yourself or others. *
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person
4. You disclose sexual misconduct of a physician or therapist.
5. Information is requested by your insurance company pertinent to processing claims for payment.
6. I receive a court order to disclose information. (e.g. child custody or mental competency cases) If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by therapist-client privilege law. Laura Atterstrom M.A. cannot provide any information without your authorization. However, if your records are subpoenaed or if a judge issues a court order for your records, Laura Atterstrom M.A. is legally obligated to comply. In the case of a subpoena, Laura Atterstrom M.A. will contact you so you (and/or your attorneys) can take steps to contest the subpoena. If you do nothing to contest the subpoena after being notified by my office, Laura Atterstrom M.A. will obey the subpoena.
7. You file a complaint with my licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.
8. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy.

*If you are deemed an imminent danger to yourself or others, I have a professional duty to contact the proper authorities. Medical and/or law enforcement officials may be notified with or without your consent.

COUPLES/FAMILY THERAPY: When seeing couples or families, I will treat as confidential (within the limits cited above) information you disclose to me that you specifically request not be shared with your partner or family member. However, I encourage open communication between couples and families, and I reserve the right to terminate treatment if I judge a secret to be detrimental to the therapeutic process. One clinical file will be maintained for the couple or family. Be aware that that this file may be accessed in its entirety only with the written consent of all the adult participants (age 18 and above), unless court ordered.

USE OF ELECTRONIC COMMUNICATIONS:

I authorize that messages may be left for me regarding appointments or returned calls...(initial all that apply)

- _____ My cell phone via voice message
- _____ My cell phone via text message
- _____ My email address that I have provided
- _____ My work voicemail

_____ I acknowledge that telephone calls from Laura Atterstrom M.A. may be returned by cell phone. Any messages I leave on the cell phone of Laura Atterstrom M.A. will contain my return phone number.

_____ I acknowledge that voice messages, emails or text messages regarding life-threatening emergencies should not be left on the cell phone of Laura Atterstrom M.A. **If you experience a life-threatening emergency, you should go immediately to the nearest hospital emergency room and request to see a mental health professional. Another option is to dial 911.** If you are suicidal you can call the Suicide and Crisis Center of North Texas Hotline at (214)828-1000. If you have insurance, call the number on the back of your card and get a referral to an in-network psychiatric hospital for consultation with an intake specialist.

_____ I acknowledge that medical records, insurance information, or other information concerning my treatment may be sent by fax transmission when a release of information has been authorized.

_____ I acknowledge that emails sent to Laura Atterstrom M.A. are checked only during business hours (not on weekends), and thus should not be used for conveying urgent or highly sensitive information. Be aware that information sent via email is not guaranteed to be secure.

_____ I acknowledge that information sent via text messages is not guaranteed to be secure.

Laura Atterstrom M.A. discourages the use of emails and text messages with clients except for the scheduling of appointments, changes to appointments or appointment reminders. While you may contact Laura Atterstrom M.A. by email, clinical responses will be provided in sessions you attend or with scheduled phone consultations. Email responses from Laura Atterstrom M.A. will be limited to acknowledging the email was received or brief responses to your request. Any email you send will be printed and become part of your clinical record.

Laura Atterstrom M.A. does not engage in communications or relationships via social media with patients. This is for the protection of your privacy as well as the therapy relationship. Laura Atterstrom M.A. does not accept "friend" requests or respond to messages from current or former clients on social networking sites since these sites can compromise clients' confidentiality and privacy.

Laura Atterstrom M.A. maintains reasonable physical, electronic and procedural safeguards the comply with professional standards to guard your non-public personal

information. By your signature below, you acknowledge that you have been advised of these limits to confidentiality.

TRANSFER OF RECORDS: In the case of death or incapacity, Laura Atterstrom M.A. has made provision for another mental health provider to take possession of all her patient records. In this event, you may contact the office of Laura Atterstrom M.A. for information concerning how to access a copy of your record or how to have your record transferred to another mental health professional of your choosing.

ASSOCIATES: The practice of Laura Atterstrom M.A. is an independent private practice separate from any therapist who may utilize office space at this location. Each therapist in this office maintains a separate and independent practice and is individually responsible for the care and the treatment of their respective clients.

CONSENT TO TREAT AND ACKNOWLEDGEMENT OF AGREEMENT:

Please Initial:

_____ I understand the nature of the proposed therapeutic treatment and I give my informed consent for psychological treatment by Laura Atterstrom, M.A.

_____ I understand that the current fee for service is \$260.00 for the Initial Evaluation for 85min. Sessions following the evaluation: 50min in length are \$170.00 and 85min sessions are \$255.00. I understand that Laura Atterstrom M.A. does not accept debit/credit cards and payment of cash or personal/cahiers checks is due at the time of service.

_____ I agree to pay the full fee for any missed appointments. To avoid a fee, I will give 24 hours advance notice if I must cancel or reschedule an appointment.

_____ I agree that if I am experiencing a medical or mental health emergency, I have been advised to dial 911 or go to the nearest emergency room, and I agree to abide by these instructions.

I hereby give my consent for psychological treatment by Laura Atterstrom M.A. I have read this document carefully and understand the information regarding consent and the services of Laura Atterstrom M.A. and policies contained herein. Any questions I had were discussed and answered to my satisfaction. I agree to comply with the policies stated. I understand that, should I require services when Laura Atterstrom M.A. is on vacation, this consent is transferable to the covering professional as designated by Laura Atterstrom M.A. If your children are to receive services from Laura Atterstrom M.A., by signing this Agreement you are acknowledging that you have legal conservatorship of your children and that you have the legal right to consent to their evaluation and/or treatment. I agree that this agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated after the date of this agreement and must be provided to Laura Atterstrom M.A. A copy of this agreement has the same force and effect as an original.

By my signature below, I also acknowledge that I have received and read the HIPAA notice of Privacy Practices. This Informed Consent is intended to cover the patient completing the form, and all minor children listed below:

Name: _____ DOB _____
Name: _____ DOB _____
Name: _____ DOB _____

Please sign below indication that you have read and agree to the terms of this Agreement.

Date

Signature of Client or Parent Name of Person Signing

Client Name Relationship to Client

Client Information

Client Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Birth date: _____

Age: _____ School: _____ Grade: _____

Occupation: _____ Employer: _____

How you heard about me: _____

Parent or Spouse Information

Mother/Wife: _____ Birth date: _____

Address (if different): _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

Occupation: _____ Employer: _____

Father/Husband: _____ Birth date: _____

Address (if different): _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

Occupation: _____ Employer: _____

Children's Information

Name: _____ M F Age/Grade: _____ School: _____

Name: _____ M F Age/Grade: _____ School: _____

Name: _____ M F Age/Grade: _____ School: _____

Medical

Pediatrician: _____ Phone: _____

Physician: _____ Phone: _____

OB/GYN: _____ Phone: _____

Current Medications: _____

Emergency Contact: _____ Phone: _____

Previous Counseling: _____

Reason for seeking counseling at this time: _____