

## **CONSENT FOR EVALUATION AND TREATMENT**

I, \_\_\_\_\_, hereby provide my consent to participate in an initial evaluation and psychotherapy with Caroline Wibbelsman, MA, LPC. I understand that the evaluation and therapy process may be distressing and may affect me emotionally. If this should occur, I understand that I can contact Caroline Wibbelsman, MA, LPC to discuss this. I agree to hold harmless Caroline Wibbelsman, MA, LPC for any consequences resulting from such evaluation.

### **CONFIDENTIALITY**

I understand that Texas state law requires that information provided to mental health practitioners remain confidential, and I make every effort to ensure that confidentiality is maintained with respect to all aspects of your treatment. As a client, you agree to the following exceptions to confidentiality, in which case information may be disclosed to the appropriate authorities/agencies/individuals:

-If I have a reason to believe that you may be a harm to yourself or others

-If I have a reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability.

-ordered disclosure by state or federal courts

In addition, I require disclosure of information in the following circumstances:

-signed release of information form granting permission to designate third parties to receive information.

### **APPOINTMENT ATTENDANCE/CANCELLATION**

I understand that the service being offered is weekly psychotherapy consisting of sessions that typically last 50 minutes. Appointments are made at an agreed upon day and time. I agree to the following policies:

-I understand that I am expected to attend all scheduled sessions.

-If I cannot attend a session, I agree to notify Caroline Wibbelsman, MA, LPC at least 24 hours in advance whenever possible.

-I understand that I will be charged the full fee for any session cancelled with less than 24 hour notice. Exceptions may be made for illness and other unforeseen circumstances on a case by case basis.

-I understand that my appointment time has been scheduled exclusively for me. Clients who frequently cancel, re-schedule, or miss appointments, especially without giving 24-hour notice, will not be allowed to retain a regularly scheduled appointment time and will be placed on the waiting list. Please let me know if our scheduled appointment times are not working for you

and I will be glad to discuss a schedule that is better suited to your needs to the best of my ability and availability. Successful therapy requires a commitment on the part of the client. It is important that you keep your appointment if at all possible.

-I understand that non-adherence to these policies may result in termination or suspension of services.

## **SESSIONS**

Psychotherapy is not easily described; it depends on a variety of factors including the personalities of the therapist and client and the particular difficulties you are experiencing. There are many different methods I may use to help you with the problems for which you are seeking help. Psychotherapy requires a very active effort on your part, and in order to be successful, you will need to work on things we talk about both during our sessions and at home. Psychotherapy has been shown to have many benefits, including better relationships, developing more effective solutions to specific problems, and a significant reduction in feelings of distress. However, there can be no guarantee of what you will experience.

Sessions are expected to begin promptly and end at the scheduled time. Although it is understood that there may be instances when you arrive late for a session, late arrival will not extend the scheduled ending time for the session. I am also expected to be on time, and will offer appropriate remedy if late, such as making the time up or pro-rating the fee.

The total number of sessions is dependent on a number of factors including your goals, time frame, rate of progress, etc. Some clients need only a few sessions to achieve their goals while others may require, or desire a much longer process. It should be noted that psychotherapy resulting in lasting changes is often a long-term process, lasting several months or longer. You, however, are in complete control and may end our counseling relationship at any time. I do request that if you wish to end the counseling relationship that you participate in a termination session. Please discuss any issues or concerns you have with me so that we can co-create an appropriate treatment plan that will best suit your needs and goals for our work together.

## **COUNSELING RELATIONSHIP**

Although our sessions may involve very personal information, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions that you arrange with me except in the case of an emergency. These boundaries are in place for your protection and to assure that the focus of our counseling relationship remains on helping you achieve your goals. It is for this reason that I will not accept or attend invitations to social gatherings, accept invitations to connect on social media, accept gifts, write references, or relate to you in any other way than in the professional manner of the counseling session.

## **FEE/PAYMENT**

Individual Psychotherapy (50 minutes) \$130.00

Couples Session (50 minutes) \$140.00

Payment is due at time of service and is accepted in the form of cash, check (made out to Caroline Wibbelsman, MA, LPC), or credit card (Visa, Mastercard, Discover, American Express). I also accept payment at the beginning of the month in advance of sessions scheduled for that month. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information (your name, nature of services provided, and amount due.) I will inform you in writing if I intend to exercise that option, to provide you with a final opportunity to make payment arrangements.

## **INSURANCE**

I am in-network with several insurance companies. If I am in network with your insurance company, as a courtesy to you, I will work directly with them in an effort to collect reimbursement allowed by your benefits.

- I will verify your insurance benefit coverage and obtain any necessary authorizations for you. **Verification of benefit coverage is not a guarantee of claim payment.** All benefits are subject to the terms and conditions outlined in your contract with your insurance company. I have no authority to make representations to you regarding coverage of items or services covered.

- It is important that you understand your benefit coverage. For benefit coverage questions, please call the customer/member service phone number on the back of your insurance card. **It is your responsibility, prior to your first appointment, to verify your plan's limitations, deductibles and exclusions.**

- In compliance with health insurance contracts, Caroline Wibbelsman, MA, LPC requires that all co-payments are collected at the time of service. This includes payments towards co-insurance and deductibles. **I do not have the option to waive co-payments, deductibles or coinsurance amounts due** as that would be a violation of the contract I have with the insurance company.

- **It is your responsibility to pay the full fee for services at the time they are rendered unless we have participating providers in your insurance plan.** You must provide your insurance card at your initial appointment so that I may keep a copy in your record in accordance with our contract with the insurance company.

▪It is your responsibility to provide me with updated information if your insurance company or plan changes or your coverage terminates. It is also your responsibility to notify me of any changes in address or other contact information. **If the insurance information you provide to me is later determined to be inaccurate resulting in a denial of your claim, you will be responsible to pay the amount denied by your carrier.**

▪It is your responsibility to pay any charges not eligible and/or not covered by your insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

▪You will receive an Explanation of Benefits (EOB) from your insurance company detailing charges, amounts you are responsible for and amounts they have paid.

▪Because I am a “fee for service” provider, I do not automatically send billing statements when there is an amount due. I will mail you an invoice on a monthly basis should you have any unpaid balance due. If you need a statement or payment itemization, please request one from me.

I authorize Caroline Wibbelsman, MA, LPC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Caroline Wibbelsman, MA, LPC. I understand that I am responsible for payment for services rendered by Caroline Wibbelsman, MA, LPC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Caroline Wibbelsman, MA, LPC immediately whenever there are changes in the client's health condition or health plan coverage in the future.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

### **AFTER HOURS POLICY/PROCEDURES**

If you need to contact me, you can leave me a voicemail and I will make every effort to return your call on the same day, with the exception of weekends and holidays. If you are having an after-hours emergency, you may call Psychiatric Emergency Services at 512.472.4357 or call 911. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact as necessary.

### **GUIDELINES REGARDING POTENTIAL COURT INVOLVEMENT**

By signing below, you are indicating that you understand that Caroline Wibbelsman, MA, LPC is acting as your psychotherapist and will not participate in court related activity, custody disputes, or other legal services. You understand that if you choose to engage Caroline Wibbelsman, MA, LPC in court related activities, that psychotherapy services will be terminated as the therapist-client relationship will have been compromised. You may ask for

clarification as needed. You also understand that additional fees apply to any court-related activities: Court appearance (door-to-door, paid in advance, minimum 4 hours): \$250/hour.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

**EMAIL, TEXT MESSAGING, AND OTHER FORMS OF ELECTRONIC COMMUNICATION**

Because I do all of my own scheduling, I often use email to make appointments with clients or their parents/guardians. Additionally, text messaging may be used to confirm appointments or inform me of cancellations or rescheduling. Electronic correspondence with Caroline Wibbelsman, MA, LPC is primarily to be used for brief and logistical matters. Email is not an appropriate forum of communication for therapeutic information, urgent matters or emergencies. I do not necessarily check email daily. Email is also not a secure form of communication; therefore, confidentiality cannot be guaranteed. I will use reasonable means to protect the security and confidentiality of all electronic communication information. Because, however, these modes of electronic communication potentially expose your protected health information, you must provide me with consent to communicate in this manner and agree to hold me harmless should an unintended breach occur. To do so, please sign here:

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

**PLEASE NOTE:** Caroline Wibbelsman, MA, LPC is an independent, licensed professional counselor and is solely responsible for her clinical practice. Other clinicians practicing in the office are separately licensed, independent practitioners and are professionally and legally responsible for each of their respective practices. Thus, unless otherwise stated in writing, Caroline Wibbelsman, MA, LPC and those practitioners are affiliated through sharing office space only.

I have read this form in its entirety and understand and agree to the information contained in it. I understand I can revoke this consent at any time, which must be done in writing.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date