INFORMED CONSENT

Thank you for choosing Heather R. Robinson, LCSW. Today's initial appointment will take approximately 60 - 75 minutes. All additional appointments will take approximately 45 – 50 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. Heather R. Robinson is a Licensed Clinical Social Worker in the state of Texas. I earned a Bachelors of Science Degree in Social Work from Texas Christian University and a Masters Degree is Social Work from the University of Texas at Arlington. I also completed 2 years post my Masters Degree to become a Licensed Clinical Social Worker in the State of Texas. I have over 12 years of experience working with children and families. I practice standard cognitive-behavior therapy for most conditions and believe in action oriented therapy that is solution focused. Other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations will be discussed with you in your initial visit.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with consultants, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Texas State Law, I am obligated to report this to the Texas Department of Family and Protective Services, d) where you sign a release of information to have specific information shared, e) if you provide information that informs me that you are in danger of harming yourself or others, f) information necessary for case supervision or consultation and g) or when required by law. **If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact emergency services in the community (911) for those services**. Heather R. Robinson, LCSW will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s)_____Date:_____

FINANCIAL/INSURANCE ISSUES: As a courtesy I will bill your insurance company, HMO, responsible party or third party payer for you if you wish. I ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, I request that you pay the balance due at that time. If your balance exceeds $300.00 I will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to a collection agency, the client or responsible party will be held responsible for any collection fee charged to my office to collect the debt owed. **I ask that every client authorize payment of medical benefits directly to Heather R. Robinson, LCSW at Southlake Counseling and Neurofeedback Center.**

If you need to cancel or reschedule an appointment, please give **24 business hours advance notice**, otherwise you will be **billed at the hourly rate**. I sincerely appreciate your cooperation and at any time if you have questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.

I have received a copy of Heather R. Robinson's, LCSW Fee Schedule

Signature(s)_____Date_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____

CLINIC:_____

ADDRESS:_____

PHONE:_____

Signature(s)_____ Date_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

Signature(s)_____ Date_____

CONSENT FOR TREATMENT OF CHILDREN/ ADOLESCENTS:

I/We consent that _____ maybe treated as a client of Heather R. Robinson, LCSW. At times it may be necessary to schedule appointments during school hours. I ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s)_____ Date_____