

THE COMPASS CENTER FOR WELLNESS, PLLC

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512 686-6341

Informed Consent and Your Rights

Therapy Overview

As a professional, I do not prescribe medications, but I am trained in a broad range of techniques. The goal of therapy is to help you resolve the problems for which you are seeking help. Therapy is a personal and unique experience for each person and family, so there is no rule of thumb regarding the number of sessions. Although it is impossible to guarantee any specific results regarding your therapeutic goals, I will work with you as conscientiously and diligently as I can to achieve the best possible results.

At times the process can make daily living more difficult. Be patient with the process, we will work together toward your goal and determine when you no longer need therapy. If you ever have questions about my services or are dissatisfied with them, please let me know. I will provide other treatment options and or referrals as necessary. My desire is to help you improve the quality of your life so you can say without a shadow of a doubt, therapy was effective and life changing.

While our sessions may be psychologically intimate, it is important for you to realize that our relationship is professional rather than social. Other than the chance meetings, our contact will be limited to the appointments you arrange with me at the office. Unlike a friendship, our relationship will concentrate exclusively upon your goals and concerns. While you might learn about me as we work together, it is important for you to remember that you are experiencing me solely in my professional role.

Confidentiality

The information that you provide in therapy is confidential and will not be shared with anyone without your written consent as prescribed by law. However, there are a few circumstances when confidentiality, by law, will not be maintained, including the following:

- Concern of imminent harm to yourself (suicide) or others (homicide);
- Crucial information regarding your physical or emotional well-being;
- Litigation brought against me or the organization by the client;
- Order for release of records by a Judge or District Attorney;
- Requirement for mental health services from disability, insurance, etc.
- Necessity for collection of any outstanding balance; or
- Any other situation required by law.

Electronic Communication

Your therapist has taken extraordinary measures to adhere to HIPAA, HITECH, and HP300 regulations, which are designed to keep your protected health information (PHI) completely confidential. However, all forms of electronic communication (e.g., text, email, e-receipt, and social media) are vulnerable to breach. Though these forms of communication can be convenient, they are not secure.

Some potential risk you might encounter include

- The message may be observed by unintended audiences, such as if a spouse read your emails/text.
- Emails and text can be mis-delivered if sent to an incorrectly typed address or phone number.
- Account can be hacked, giving 3rd party access to vulnerable information.
- Emails providers (e.g., Gmail, Yahoo) keep a copy of each email on their servers, where it might be assessable to their employees.

It is within your rights to request only non-electronic communication with your therapist in order to protect your confidentiality

Do you consent to receiving electronic communication from your therapist? ___Yes ___No

Coverage/Emergencies

The Compass Center for Wellness, PLLC **is not a crisis counseling center**. If you are experiencing danger or a life-threatening emergency, call 911 or go to your nearest emergency room immediately. If you need to contact me between sessions, call 512 686-6341. If I am unavailable, I will return your message as soon as I am able or within 24 hours. Contact between sessions, including phone calls, text, or emails may require an additional session fee, except for appointment setting information.

Session/Fees

Therapy sessions are typically 50 minutes in length, the remainder of our hour is used to chart notes, file insurance claims if applicable, and return client phone calls. A fee will be arranged between client and therapist before the initial session. . Any fees incurred are due at the time services are rendered. Acceptable forms of payment include cash, check, money order, Zelle Chase, at the present time. There will be a \$40 charge levied on all returned checks. There is a \$75 fee for each request for client records or letters written on the client's behalf. If you are receiving services paid for by another party, the fees remain your responsibility until paid.

Appointment and Cancellations

Regardless of whether I call to confirm your schedule appointment, your appointment time has been reserved specifically for you, and then on time will ensure that you receive the full time scheduled. If you cannot keep your scheduled appointment, kindly called to cancel at least 24 hours in advance so that someone else can be seen for services that day.

- A responsible parent or adult must be present on site for the entire duration of the session for children under age 16. Children under the age of 10 **cannot** be left unattended in the waiting room at any time.
- There is no charge for cancellations made at least 24 hours prior to appointment time.
- There is a session fee, or for schedule appointments cancelled less than 24 hours prior to appointment time. This fee must be paid prior to scheduling your next appointment.
- If you miss or cancel 3 scheduled appointments, I will no longer be able to work with you. However, I will provide referral sources so that you can continue treatment elsewhere.
- Unfortunately, there are occasions when I am behind schedule. In this case you will receive the full 45-50 minutes of your scheduled appointment.

Client Rights and Agreement

I understand that I have chosen to undergo therapy, that this choice is voluntary, and that I may terminate treatment at any time. I understand that there is no assurance that I will feel better. Because therapy is a cooperative effort between my therapist and me. I will work in a corporative manner to resolve my difficulties. I understand that during my

treatment, subject matter maybe discuss that is of a sensitive nature, and that this may be necessary for me to resolve my problems.

I understand that my therapist, Alessia F. Madkins, M.A.,LPC and/or any other of The Compass Center for Wellness, PLLC staff member, including the therapist may exchange any and all information pertaining to my therapy to the extent that such disclosure is necessary for the processing of payment, case management, coordination and/or continuity of treatment, quality assurance, outcome assessment, or utilization review purpose. I understand I can revoke my consent in writing at any time, except to the extent that treatment has already been rendered or action has been taken in reliance upon this consent. If I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid.

_____ I have been offered a copy of TCCFW, PLLC Notice of Private Practice policy informing me of my privacy rights, TCCFW, PLLC duty to protect the health information that identifies me, and how TCCFW, PLLC may use or disclose health information that identifies me with or without my permission. I understand the Notice of Private Practice policy does not apply to health information that does not identify me or anyone else.

I understand that I have a right to contact the Texas Board of Examiners of Professional Counselors at 512 834-6658 if I am concerned about any ethical impropriety. I also understand that I may choose to voice my concerns to Alessia F. Madkins M.M., LPC, Executive Director of The Compass Center for Wellness, PLLC, as well.

I understand that if I am signing consent for a minor (17 years and under), I have authority to give consent. I will provide proof in the form of legal documentation.

I have read, understand, an agree to these policies:

Client Signature: _____	Date: _____
Client Signature: _____	Date: _____
Parent Signature (if minor): _____	Date: _____
Therapist Signature: _____	Date: _____