GULF COAST CHRISTIAN COUNSELLING
Jerry Heiderich, MMFT
Licensed Marriage and Family Therapist
Preston Place
12700 Preston Rd. Suite 135
Dallas, TX 75230
214 862-8964

Therapeutic Consent and Client Contract

Please read the following policies carefully. If you have any questions or concerns, please discuss them with your therapist before signing below.

Therapy Expectations

Your first therapy session is a time to discuss your reasons for seeking treatment and gather adequate information from you to make a treatment plan for your mental health care. A treatment plan and expected length of treatment will be discussed with you. If other goals surface in future sessions, these will be discussed with you as they arise. With your permission, often I will assign homework to expedite your healing. I take homework seriously and ask that you be ready to bring up and discuss your homework at the next session.

It is your responsibility to share any relevant information about yourself and your situation that could help me understand how best to help you. If I do not directly ask you about a matter that could aid in treatment, please volunteer this information instead of waiting for me to ask just the right question. This is both your right and your responsibility to yourself.

As therapy progresses, there is often a "phasing out" process where you come to therapy less often as you begin to achieve your goals for treatment (i.e. initially come weekly, then every other week and then monthly). If you continue therapy after our initial session, I ask for a commitment that you not end treatment without a face-to-face discussion. A phone call or cancellation of a session to end treatment is not in your best interest and does not allow you to work through your personal or therapeutic concerns. All patients are asked to come in to have a final termination session to discuss progress and gain closure to the counseling process.

Notice of Privacy Practices

When one receives care for mental health and/or substance abuse, information related to that care might be more protected than other types of health information. Communications with a therapist in treatment are privileged and may not be disclosed without your written permission, except as required by law. The following are situations in which a mental health professional is required by law to reveal information obtained during therapy to other persons or agencies without the client's permission: (a) If a

client threatens bodily harm or death to him/herself or to another person; (b) If a court of law issues a legitimate court order (signed by a judge), the practicing therapist will be required by law to provide the information specifically described in that order; (c) If a client reveals information relative to child abuse, child neglect, or elder abuse (past or present). Also, (a) If a client presents to therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; (b) If any sexual improprieties by a former therapist are reported, the therapist must report this to the state licensing board; (c) If any sexual improprieties by clergy are reported, the therapist must report this to the district attorney; (d) If a client is seeking reimbursement through an insurance company, it will be necessary to reveal confidential information to them; (e) Banks and credit card companies may be made aware that a person is receiving services from GCCC due to check or credit card processing; (f) If a client files a complaint or malpractice suit against a therapist, the therapist reserves the right to use his or her records to defend him or herself in court. A client's records may also be used to sue for delinquent payment.

Protection of client confidentiality is of utmost importance. At GULF COAST CHRISTIAN COUNSELING (GCCC) we uphold the highest standards for guarding your personal information. A client's personal, written consent is required should the need arise for one's information or records to be shared for any other reason than those required by law as stated above.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger physically, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel.
Initial _____

Name _____ Telephone Number_____

Informed consent for Telephone, Electronic, and Mail Contact

I understand communication through telephone, and other electronic means is not completely confidential to the extent that spyware and other dangerous hardware can gain access to protected material. I also understand text messages and emails will be kept in a password-protected account to which only my GCCC therapist has access. I trust my therapist will handle my private information respectfully and with care in order to protect my confidentiality. It is recommended that clients keep electronic communication brief and vague. Please do not write any information in an email, which you would not want others to know. Email is best used for appointment setting, initiating a phone call, or asking questions about Gulf Coast Christian Counseling and it's therapists. Initial _____

The Client-Therapist Relationship

The ethical code of marriage and family therapists prohibits dual relationships between clinician and patient. This means a therapist cannot engage with a client in any social occasion or through social media. Therapists and clients also may not be involved in any business activities other than providing psychotherapeutic services. In order to further protect client confidentiality, the therapist will not acknowledge past or current clients in public unless the client first initiates the conversation. This prevents clients from being unwillingly put in a position to explain his or her relation to the therapist if asked by a nearby person.

Grievance Procedure

Jerry Heiderich, MMFT, LMFT, a Master's level therapist, is licensed by the Texas Association of Marriage and Family Therapy. Should you need to file a formal, ethical complaint against a license holder, you may contact the Texas Department of State Health Services' Complaints Management Section at 1-800-942-5540.

Financial Agreement

You have the right to be informed of the cost of services rendered to you. Please read carefully:

- Payment of $95 is due in full at the time of services rendered unless previous arrangements have been made. Since your progress in therapy is often affected by your consistency in attending counseling sessions, it is strongly suggested that you make every effort to adjust your schedule so you will be able to keep scheduled appointments. However, if you are unable to keep an appointment, please notify the office immediately at 214 862.8964. **We require that you notify your therapist at least 24 hours in advance should you wish to cancel or reschedule an appointment. The fee for a late cancellation is $95.** Missed sessions without a minimum 24-hour notification to your therapist will result in being charged your regular session fee in full. The penalty charges are not allowable charges for insurance and are the sole responsibility of the client.
- Each session is 50 minutes.
- Any phone call lasting over 25 minutes will be billed as a full therapy hour at $95.
- Any document preparation will be billed at $95, plus an additional $95 per hour beyond the first hour of the therapist's time.
- Other fees include a $30 service fee for checks returned for non-sufficient funds. Before any future visits occur, the client or responsible party must pay the service charge plus the value of the check.

Minor patients: The parent or guardian accompanying the minor is responsible for full payment when services are rendered.

Gulf Coast Christian Counseling reserves the right to charge a client based on his or her individual need. Initial _____

Fees Specifically Related to Legal Proceedings and Court Involvement

In the event a client requires his or her therapist's testimony or involvement in legal or court proceedings, client consent will be required. The therapist will be unable to disclose any information pertaining to other family members or parties in counseling without each person's specific consent. Court appearances, either requested or subpoenaed, as well as depositions and settlement conferences are billed at an hourly rate of $180.00. These rates will be charged at a minimum of four hours, which includes time spent on preparation, travel, waiting, and testimony. The initial minimum four-hour charge of $600 is due at the time of the subpoena. These charges are not allowable charges for insurance and are the sole responsibility of the client. Because it is often difficult to accurately determine the time needed to appear in court, there is a need for the therapist to clear his or her appointment schedule for the entire day. Such scheduling makes it necessary to charge in this manner

Initial _____

Incapacitation/death

I acknowledge that, in the event the undersigned therapist become incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing a licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request or to deliver them to a therapist of my choice. Initial _____

I, the undersigned, request treatment from Jerry Heiderich M.MFT, LMFT for outpatient mental health services and hereby authorize the clinical staff to administer such treatment as deemed necessary. I also certify no guarantee or assurance has been made as to the results or outcomes that may be obtained. Risks of treatment include potential for both emotional and relational discomfort related to issues discussed during the counseling process. I understand I am free to discontinue therapy at any time. I am aware this counseling office is not an emergency or 24 hour service. In the case of an emergency, clients are requested to call their primary care physician or 911.

Initial _____

Signature

I certify the information, which I have provided, on this form is true and accurate. I have read and understand the above rights, authorizations, and responsibilities and have signed below to indicate my agreement with these terms. I have also read and understood the *Notice of Privacy Practices* and have signed below to indicate my agreement with its terms as well.

_____

Client and/or Guardian's Signature Date

_____

Client Printed Name Date

Client Date