Janice Terry Counseling Services
Scott Grizzle, LPC Intern

INFORMED CONSENT / POLICIES & PROCEDURES AGREEMENT

Thank you for choosing me and Janice Terry Counseling Services. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, state and federal laws and your rights. If you have other questions or concerns, please ask and I will try to give you all the information you need.

TRAINING AND QUALIFICATIONS:

I am Licensed by the Texas Board of Examiners of Professional Counselors as a Licensed Professional Counselor Intern (LPC Intern). I received a Master of Arts Degree in Professional Counseling from Amberton University in Garland, Texas. I also have a Master of Arts degree in Bible and Theology. My training qualifies me to offer individual, couples, relationship, and/or group counseling. If our work together indicates that there are issues beyond my personal expertise, I will refer you to an appropriate practitioner that may better provide necessary services.

SUPERVISION CONSENT:

As an LPC Intern, I am under supervision by Jenifer Martin, Licensed Professional Counselor Supervisor (LPC-S), to ensure that you receive quality counseling. Details of your case may be shared with my supervisor, who is also bound by the rules of confidentiality. If you are dissatisfied with my services at any time, I encourage you to discuss it with me first. However, you may contact my supervisor at any time at 4101 University BLVD, Tyler, TX 75701 or 903-926-4505.

COUNSELING PURPOSES, GOALS AND TECHNIQUES:

My philosophy of counseling is to enter your life on whatever level you invite me in and walk with you to achieve mutually agreed upon goals. My desire is to see you overcome the obstacles in your life so that you can reach forward to the quality of life you desire and deserve. Although no one can solve problems for you, it is my hope that you will be better able to understand your situation and feelings and move toward achieving a higher degree of mental health.

It is my responsibility to listen, understand and be helpful to the fullest extent of my professional ability. I use an integrated approach to counseling that includes various theories and techniques tailored to your specific needs. My overall approach is Cognitive Behavioral Therapy (CBT), which helps you understand the relationship between thoughts, feelings and actions. I also help clients with an existential approach that examines the deeper issues of the heart and how one finds meaning in life.

It is your responsibility to help me understand your life situation, thoughts, feelings and to have the courage to try new approaches in order for change to occur. It is important that you share with

me the goals you have for therapy and realize that entering therapy does not always guarantee anticipated outcomes.

CONFIDENTIALITY:

Communications between the therapist and you, including records, are confidential under the Texas Health and Safety Code and other state and federal laws. It is my goal to protect the confidentiality of your private information. In almost all cases, it is my intent to use your personal information or share with other professionals only for the purposes of providing treatment to you. However, the following limits to confidentiality may be required and/or authorized by law:

- Threat of harm to yourself or others
- Report of or suspected abuse or neglect of a child/elderly or disabled adult
- Subpoenas or court orders
- Discussions with my supervisor

In addition, you may at times give the therapist written authorization to use your personal information or to disclose it to another person for the purposes you designate.

If you have any questions regarding confidentiality or the Privacy Practices, you should bring them to my attention. By signing this Informed Consent Agreement, you are giving your consent to me to use and disclose your personal information as outlined above. You are also releasing and holding harmless, Scott Grizzle and Janice Terry Counseling Services from any departure from your right of confidentiality that may result. While we make every effort to provide confidentiality, we cannot assure the confidentiality of family members or other individuals you may include in the therapy process.

RECORDS:

Client records and files will be stored securely to maintain confidentiality. When clients are referred and seen through a contracting agency, records produced by those agencies are ultimately their property.

BOUNDARIES:

There may be occasions where you see your therapist outside this office. To protect your privacy, the therapist will not initiate conversation or discuss clinical issues with you in social or public situations. Your relationship with the therapist is professional and therapeutic. Personal and/or business relationships undermine the effectiveness of therapy and will be avoided.

APPOINTMENTS:

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Scott Grizzle, LPC Intern

Services are by appointment only. Appointments are made by calling (903) 576-9003. Counseling sessions will not be conducted through text messages. Please leave a message if unable to reach me. Messages are checked frequently and I will attempt to contact you within 24 hours of any messages left. If possible, please call to reschedule or **cancel 24 hours in advance** of a scheduled appointment to avoid a charge for missed appointments. I understand emergencies may occur and together we can determine if cancellation was due to a true emergency. There may be a waiting time for prime appointments, but I will do my best to offer convenient appointment times for you. **Please make every effort to keep your appointment times and honor the time set aside for you.** You may also leave messages unrelated to cancellations—please state the time and date on the message.

On-going therapy is a negotiated process, and the need for follow-up appointments will be discussed with you at the close of each session. Whether you reschedule is always your choice. However, when therapy is completed or if you decide to discontinue therapy, a closure session should be scheduled. Therapy may be discontinued if you cease to benefit from counseling, or if I assess that your situation requires intervention beyond the scope of services I am qualified to provide. Termination of counseling will be discussed and handled with patience and care.

An average session lasts between 45-50 minutes. This is referred to as a "clinical hour" and the remaining time is used for documentation. This provides a break between sessions and facilitates privacy for clients coming and going. Complex issues may require a longer session. If you think your situation will require additional time, please request this when you schedule. Late arrivals should expect to forfeit the portion of the hour missed. You are responsible for calling to cancel or reschedule your appointment. When you schedule an appointment, I agree to set aside that time for you.

IN TIMES OF CRISIS OR EMERGENCY:

If you experience an emergency or crisis, please contact local law enforcement, your local emergency room, or call 911. If you are having thoughts of suicide, please call 911 or the **National Suicide Hotline at 1-800-273-8255.**

TREATMENT WITH CHILDREN AND ADOLESCENTS:

Whether you are requesting services for a child as the guardian, the parent, or Managing Conservator, the same policy applies. When making an appointment for a child, a consent for counseling must be signed by the parent or in the case of a divorce, by the managing conservator of the child, prior to contact with the child. An initial appointment is scheduled with the parents to obtain a history regarding the child's problem. (Please be prepared to provide a copy of the court order naming the managing conservator of the child). It is our policy that both parents may be involved in a child's therapy.

It is critical that the child/adolescent trust me. With your understanding in advance, I shall keep what your child/adolescent says and does confidential as I would with an adult. If I think it would be beneficial to share a specific detail with you, I shall first ask the child's permission. It is important the child not feel like the counselor is siding with the child, the parents, or one parent over another parent. You do have the right to question the therapy process, to understand the nature of activities and to be informed of the child's progress. We will work as a team by you sharing your concerns of your child's behaviors in various settings, while I share progress of your child in counseling. We will have consultations as needed and recommendations may be given for adults and others in the child's life. This helps ensure that you can be a part of your child's therapy and still maintain the child's confidentiality. My role is to act as the child's helper and not to ally with any disputing party regarding the child. Counseling is for the purpose of the child's emotional well-being and does not yield recommendations about custody issues. Parties that are disputing over custody should request an independent custody evaluation if an opinion is sought regarding custody issues.

ADDITIONAL TREATMENT:

During counseling, various professional recommendations may occur such as psychological evaluations and/or a consult with a medical doctor for possible medication or ruling out a possible medical condition. Other treatment options may also be discussed and referred to better determine the best way to help your child, yourself, and/or your family. At any time, you may question and/or refuse therapeutic or diagnostic procedures. The choice to follow through with recommendations is yours; however, the counselor reserves the right to discontinue counseling if the choice not to follow recommendations and/or the lack of cooperation is considered harmful to the clients. For example, if a child is exhibiting concerning behaviors and a counselor needs a psychological evaluation to help determine the best counseling/treatment and/or a medical consultation—counseling alone may not help the client if these things are not completed.

PAYMENT FOR SERVICES:

Before sessions are scheduled, payment arrangements will be made. We do not file for reimbursement with your insurance company. Payment is made by cash, check or credit card at the beginning of each session. All checks should be made payable to Janice Terry Counseling Services.

Fees for services: Counseling fees for Scott Grizzle are $60.00 per counseling hour (45-50 minutes) for individual or couples paid to Janice Terry Counseling Services. We will look to you for full payment of your account at the beginning of your sessions. Gifts, bartering and trading services are not appropriate. Failure to provide payment at the beginning of your session without prior arrangement will result in the appointment being rescheduled after the second occurrence.

THERAPIST'S/CLIENT'S INCAPACITY OR DEATH:

I acknowledge that, in the event Scott Grizzle becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this form, I give my consent to allowing another licensed mental health professional selected by Janice Terry 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. Confidentiality also extends beyond your death. In the event of your death, you would like your records released to: _____

_____

DUTY TO WARN:

In the event that my therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for him to warn the person in danger, contact medical and law enforcement personnel, and notify the following person(s):

Name **Telephone Number**

_____

_____

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN (Optional)

I authorize Scott Grizzle, LPC Intern, to release information to and obtain information from the following:

Primary Care Physician Name:_____
Phone:_____
Address:_____

Other: _____
Relationship: _____
Phone: _____
Address: _____

Signature:_____**Date:**_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

Janice Terry Counseling Services

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Minors under the age of 18:

Name of Minor Child: (please print)_____

I/we consent that (child's name)_____

_____

may be treated as a client by Scott Grizzle, LPC Intern.

Printed Name of Parent/Guardian: _____ **Date:**_____

Signature of Parent/Guardian: _____ **Date:**_____

Date the other Parent was informed of Counseling: _____

CONSENT TO CONTACT:

I consent for my therapist to communicate with me by mail and phone at the following location, & number, and I will provide timely notification of any changes.

Address **Telephone Number**

_____

_____

INFORMED CONSENT TO TREATMENT:

I voluntarily agree to receive mental health assessment, care, treatment or services for myself and family members noted below and authorize my therapist to provide such care, treatment or services considered necessary and advisable to myself and others listed below:

Please indicate any individual(s) who you may want your therapist to confer with during the course of your therapy (i.e. physician, spouse, parents, children, etc.) Your signature authorizes two-way consultation with the persons listed and releases your therapist from liability resulting in the release/obtaining of information.

Name(s)_____**Relationship**_____

Name(s)_____**Relationship**_____

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Name(s)_____**Relationship**_____

I understand that as part of my healthcare, the undersigned therapist originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment, psychotherapy/counseling notes, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to communicate with other healthcare providers and other routine healthcare operations, such as assessing quality and reviewing competence of healthcare professionals. I understand and agree that I will participate in the planning of my care, treatment or services, and that I may stop such care, treatment, or services that I receive through my therapist at any time.

I agree to discuss with my therapist any questions or concerns I have about my therapy and to schedule a closure session when therapy ends. Should a dispute arise between me and my therapist, I agree to good faith mediation to find resolution.

By signing this form, I, the undersigned client, acknowledge that I have read and understand all the terms and information contained herein; that ample opportunity has been offered to me to ask questions and seek clarification.

_____

Client/Parent **Date**

_____

Address **Social Security Number**

As witnessed by:_____

Scott Grizzle **Date**

1820 Shiloh Road, Suite 1405, Tyler, Texas, 75703 – 903.576.9003 – grizzles22@gmail.com