Elissa Shaw, M.Ed., LCSW
Sanctuary Psychotherapy
2111 Dickson Drive #33
Austin, TX 78704
Phone (512) 965-9863
elissa.psychotherapy@gmail.com

CLIENT & COUNSELOR AGREEMENT

Name of the Client:_____ DOB:___/___/___
Address:_____ City:_____ State:_____
Zip:_____
Primary Phone Number:_____

Referral Source:_____ Referral's Phone Number (if applicable):_____

Primary Care Physician's (PCP) Name:_____ PCP Phone Number:_____

Secondary Physician's Name:_____ Physician Phone Number: _____

Please list any medical/mental health conditions and medications you are currently on:
_____
_____
_____
_____

1. Name of the Primary Insurance Co (on the front of the card): _____
Name of the Behavioral/Mental Health Subcontractor (usually on the back of the card):_____
Customer Service Phone Number for Providers (for Behavioral/Mental Health):_____
I.D. Number (on the front of the card):_____Group #:_____
Relationship to Client:_____
Billing Address:_____ City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ DOB: ___/__/___

2. Name of Secondary Insurance Company, if applicable (on the front of the card): _____
Name of the Behavioral/Mental Health Subcontractor (usually on the back of the card):_____
Customer Service Phone Number for Providers (for Behavioral/Mental Health):_____
I.D. Number (on the front of the card):_____Group #:_____
Relationship to Client:_____
Billing Address:_____ City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ DOB: ___/__/___

_____(initials) I hereby authorize Elissa Shaw, LCSW to share information to my insurance companies concerning the client's diagnosis and treatment. I hereby authorize Elissa Shaw, LCSW to provide treatment for me and/or my dependents. I authorize payment of therapeutic services to Elissa Shaw, LCSW.

_____(initials) It is the responsibility of the patient to keep this office informed of any changes in insurance, residency &/or phone number as soon as possible. If you do not inform of us of the changes, you agree to pay for all fees not covered by your current or previous insurance companies.

_____(initials) Consent for Participation in Counseling – By initialing to the left and signing below, I verify that I am the parent or legal guardian of the above-named minor, and that I have the legal right to give consent for the above-named minor to participate in counseling sessions conducted by Elissa Shaw, LCSW.

Fees for services are as follows:

- Addictions Assessment $___NA_
- Individual Psychotherapy $__130__
- Documentation $___35____

All fees (co-pays, co-insurance payments, etc.) are due and payable at the time of service.

If you are a private paying client, you agree to pay $___130___ per session at the time of the service.

_____(initials) **Court:** I do not testify in court as a witness. If you are seeing me for marital therapy or if there is a custody dispute, I will not be available for court testimony for either party. In rare circumstances, where I might be required to testify in civil court by subpoena, I will require payment in advance of $150.00 per hour during the entire time at the court or at the depositions, including travel time.

_____(initials) **Phone Calls:** After 10 minutes of phone contact there will be a $1 a minute charge.

_____(initials) **Cancellation Notice**: There is no charge for cancellation of appointments if notice is given more than 24 hours in advance. An administrative fee of $100.00 will be charged if you give less than 24-hours notice. This fee is not covered by any insurance companies.

_____(initials) Additionally, if for any reason you have to cancel your appointments for two consecutive sessions, your reserved appointment time may be released. However, every effort will be made to re-schedule your appointment based on your therapist's availability.

_____ (initials) **Credit Card Authorization**. It is the policy of this practice that you maintain a current credit card on file to cover missed appointments. This practice uses a service with secure data encryption.

_____(initials) **Assessment Information:** In addition to the limitations mentioned below, I understand that if I am referred by a professional association, licensing board, or legal entity for an assessment, I will need to sign releases for these entities and the information obtained during the assessment process will be shared accordingly. I also understand that additional consents may be requested in obtaining collateral information specific to my case.

_____(initials) **Assessment Revocation of Consent:** I understand that should I decide to revoke consent

for communication in an assessment process, that I will be responsible for the cost of the assessment.

_____(initials) **Confidentiality:** Information that you discuss with your therapist is usually confidential and will not be discussed with anyone not covered under the HIPAA regulations. This means that under most circumstances what is told in a therapy session will not be reported to anyone, even to other family members (except for therapeutic purposes, in case of a minor). However, there are limits to confidentiality under any of the following circumstances:

1. If a court of law orders your records.
2. If you threaten to harm yourself.
3. If you threaten to harm others.
4. Reports of abuse of children and/or elderly individuals
5. If you are using a mental health insurance policy to pay for your visits, we may be required to provide certain diagnostic and treatment information in order to obtain payment for our services.
6. To coordinate services with your primary care provider, your psychiatrist, your referring doctor and/or other relevant providers as stated in the HIPAA regulations. You may ask for a copy of the HIPAA regulations at any time. Additionally, there is a copy of the HIPAA regulations posted in the therapist's office or in the waiting room.
7. Please be advised there is a risk that a breach of confidentiality could occur should you choose to text or email Elissa Shaw, LCSW by phone or on-line. To decrease the risk of breach of confidentiality, verbal contact by phone is recommended.

_____(initials) **Consultation:** At times this clinician may seek consultation for your case. Should consultation be sought no identifying information will be provided including: name, age, date of birth, social security number, identifying physical characteristics, associations, or any information that would lead to recognition of you as a client at this practice.

_____(initials) **Referral Policy:** Referrals will be provided for clients to professionals in the community when this practice is unable to best meet the needs of the client.

_____(initials)The therapeutic relationship is unique in that it is a highly personal, and, at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

_____(initials) Regarding the therapeutic process.You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

_____(initials) In the event that my therapist, Elissa Shaw, LCSW becomes incapacitated or deceased, I understand I will be notified via Hanna Del Toro, LCSW who will access my contact information only in the events mentioned above.

If you have any questions about the above information, or if you have questions about a specific situation, please feel free to discuss your questions with your therapist.

Client Signature & Date:_____

Therapist Signature & Date:_____