S. Renee Turner, Ph.D., LPC
Expressive Therapies Institute, PLLC

THERAPY INFORMATION AND CONSENT TO TREATMENT

The purpose of this document is to ensure that all participants in the therapeutic process are aware of their rights and responsibilities when entering into a therapeutic relationship with me. I encourage you to ask questions about any of these topics at any point during the time that we are working together.

THE THERAPEUTIC RELATIONSHIP

Research has found that the best outcomes occur in therapy when all members of a client system develop a positive relationship with their therapist. My first priority is to establish a relationship with each individual or member of a family, allowing them to feel comfortable and safe discussing and processing any situation. I seek a collaborative relationship with you in which you not only feel understood and valued, but also feel ownership in your therapeutic process. I am trained and experienced in a number of therapeutic models and will collaborate with you regarding the best treatment plan for your needs. I will regularly discuss the goals of therapy to ensure that we are in agreement, and I will work to ensure that you are comfortable with any planned or suggested intervention approach. I invite you to share with me any questions, concerns, or suggestions during the course of our work together.

Also related to safety for all parties, I have a strict policy of prohibiting weapons of any kind into my office during the psychotherapy process. If you are licensed to carry a weapon or are coming to therapy from a job that requires you to be armed, please make plans to secure your weapon outside of my office.

CONFIDENTIALITY AND LIMITS TO CONFIDENTIALITY

In general, the privacy of all communications between you and me, and even the fact that you are a client, is confidential and protected by state and federal law. Generally, I can only release records or information about our work together to others outside our therapeutic relationship with your written authorization. There are some important exceptions to confidentiality, which include the following:

1. If you are involved in a court proceeding and a request is made for the information concerning your diagnosis and treatment, that information is protected by the therapist-client privilege. I cannot release records or provide any information without your written authorization. However, if your records are subpoenaed or if a judge issues a court order for your records, I am legally obligated to comply. In the case of a subpoena, I will contact you so that you (or your attorney) can take steps to contest the subpoena. If you do nothing to challenge the subpoena after being notified by me, I will comply with the subpoena.
2. If I believe that you are a danger to yourself or to other persons, I may contact medical or law enforcement personnel.
3. If you disclose information that leads me to suspect that a minor child, an elderly person or a disabled person is being abused or neglected, I am required by law to notify authorities within 48 hours and I will comply with this requirement.
4. If you file a lawsuit or a complaint against me for any reason, I am allowed to use confidential information to defend myself.
5. If a court order or other legal proceeding (such as a grand jury) requires the disclosure of your information or records, I will obey the court order or the grand jury subpoena.
6. If you waive your privilege or give written authorization to disclose information, I will comply with your authorization.
7. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy.
8. If I learn of previous sexual exploitation by a mental health provider, I am required to report it to the District Attorney in the county of the alleged exploitation and the appropriate licensing board of the provider.
9. The matters discussed during a family therapy session or couple's therapy session are not confidential as to the persons present since those persons hear the statements

made and participate in the discussion. However, all matters discussed during the family or couple's sessions are confidential and privileged as to third parties who were not present in the session.

As a child and family therapist, I also have unique confidentiality responsibilities when working with parents, families, and children because the family as a whole may be considered the client. When working with families, I have an obligation to more than one person. I may share information disclosed to me in individual sessions, phone conversations, or written messages with those family members who have consented to treatment with me. **I have a strict policy of not keeping potentially hurtful or damaging secrets from other family members who are also participating in therapy.** It is my goal to earn a level of trust from you that allows you to feel comfortable sharing secrets with me privately and then working together to plan for sharing information with other clients as appropriate. Please keep this in mind as you share information with me. **If you share a potentially damaging secret with me, and refuse to share it with other participants in therapy, I may be forced to terminate relational therapy. If you must discuss personal information that cannot be shared, please request a referral for individual therapy.**

Clients often prefer to communicate with me via email or text message to schedule or confirm appointments, as well as provide updates regarding their situations. While I have a duty to act with professionalism and diligence to protect your information, I cannot guarantee the confidentiality of email correspondence and text messages due to the logistics of these types of communication. I will comply with your informed requests are described in the Communications Form regarding use of texts, emails, or other communications outside of face to face communication in my office. Text communication is reserved only for scheduling appointments and other logistical issues, such as to inform me that a client is running late to a session.

Another important element of confidentiality is the expectation that participating parties respect the privacy of other participating family members by refraining from sharing contents of the sessions with outside parties. **Further, recording devices of any kind (audio, video, or photographic) are not allowed in the therapy sessions without written consent of all parties attending, including your therapist. Please turn off all cell phones and electronic devices in your possession when you enter my office.** In order to achieve your therapeutic goals, it is essential for all parties to experience trust and personal safety during therapy sessions.

THE BENEFITS AND RISKS OF PSYCHOTHERAPY

One major benefit that may be gained from participating is the resolution of concerns. Other possible benefits may be a better ability to cope with marital, family, and other interpersonal relationships, as well as a greater understanding of personal goals and values. However, seeking to resolve concerns between family members, marital partners, and other persons can also lead to discomfort as well as relationship changes that may not have been originally intended. The greatest risk of psychotherapy is that it may not by itself resolve your concerns. You may also experience discomfort such as anger, depression, or frustration during your treatment as you remember and resolve unpleasant events. I will do my best to assess progress on a week-to-week basis, and I encourage you to notify me of any changes in your condition. If a situation fails to improve or a situation deteriorates, I will provide referral to another professional for consultation or treatment.

Please know, too, that I do not provide emergency mental health services. I may not able to return your calls immediately or schedule you for immediate treatment. In the event of an emergency, you have several options. You may go to the nearest emergency room, call 911 for emergency assistance, or contact the Crisis Stabilization Unit of the Center for Health Care Services at 800-316-9241 or 210-223-SAFE (7233). You may also call the United Way HELP Hotline by dialing 211.

FEES AND APPOINTMENTS

A standard therapy hour consists of approximately 50 minutes for the therapy session and 10 minutes to allow me to complete necessary paperwork and prepare for my next client. **My fee for a standard therapy hour is $150 for individual therapy and child-focused therapy (unless court ordered)**

including sessions spent in individual conversations that are part of these services. You may pay by cash, personal checks, and major credit cards. Payment for psychotherapy is due at the time services are rendered. To avoid accumulation of a balance, clients are asked to complete a Billing Agreement and provide credit card information to remain on file during the time they are active clients. Credit cards will only be billed for services provided, returned check fees, or no-show/late cancellation charges. Credit card information is securely destroyed 60 days after your last session or immediately upon your communication that you are terminating the therapeutic relationship. Clients who do not wish to leave credit card information on file may elect to instead make a retainer payment equal to 3 session fees when scheduling the second therapy session. A $30 fee is charged for each check returned by your bank.

I am not an "in-network" provider for any insurance companies; however, I will complete necessary paperwork if you elect to submit your own claim for my services to your insurance company for reimbursement. Please be aware that insurance companies require a mental health diagnosis to be assigned to a single, identified client to consider psychotherapy to be medically necessary, and thus eligible for reimbursement. If my professional assessment does not determine a mental health disorder to be present or relevant to the therapy provided, I will not be able to complete a claim for your insurance company. Furthermore, I will review with you any diagnosis assigned to you to be submitted to your insurance company. Upon request, I will provide a detailed monthly invoice for services, including relevant codes your insurance company would require and complete your insurance company's claim form. The first page of the claim form is completed at no charge; more complex forms are completed at $20/page.

Sessions are by appointment only. If you must cancel or reschedule an appointment, I require at least 24 hours notice so that I may have the opportunity to schedule another client during the appointment time. **Clients who do not provide 24 hours notice that they will not be attending a scheduled session will be billed the full fee for the therapy hour.**

At various points in treatment, we will discuss progress that has been made, remaining goals, and the expected time frame for treatment. Your participation in therapeutic services, though, is completely voluntary and you may stop at any time.

PROFESSIONAL CONSULTATION AND SHARED OFFICE SPACE

I meet regularly with other licensed mental health professionals at the ICFE for peer consultation to ensure that my therapeutic skills remain strong. In peer consultation, I may share information about your clinical case in confidential format with no names or other identifying information. Further, I am a clinical supervisor for licensed professional counselor associates (LPC-Associates) and discuss current and past clinical cases, again in confidential format, with supervisees for training purposes. If I am aware of, or become aware of, an existing relationship between you and my colleague or supervisee, I will not share any details about your clinical case to protect against the possibility of your identity as a client becoming recognized.

I also share office space with other therapists who are independent contractors providing services at the ICFE. Our clinical records are stored in a common area, which means that these other therapists may have access to your confidential information. Anyone affiliated with the ICFE who has access to clients' private and confidential information is obligated by law and professional ethics to protect clients' confidentiality.

RECORDS

All of our communications become part of a clinical record, which is maintained in the form of paper and/or electronic files once the clinical services are complete. Texas law requires that I maintain appropriate treatment records for at least six years from the last date of service for adult clients. I will not release any information about you to anyone without your written consent unless required to do so by law.

As a client, you have the right to obtain a copy of your records upon submission of a written authorization. Texas law requires that all requests to review or obtain copies of your records must be made in writing. The records of your treatment will contain confidential information about you and the information in the

records can be misinterpreted or upsetting to lay readers. If you request a copy of your records in writing, I will provide them to you upon payment of the records fee unless I believe that releasing the records would endanger your life or physical safety, or the life/physical safety of another person. If I believe that I must withhold the records due to a situation involving life or physical safety endangerment, I will write you a letter to explain my reasons for withholding the records.

For family or couple's therapy, the family's or couple's relationship is as much of a "client" as the individual parties. For that reason, I will not release my records of couples counseling unless both of the individuals pay the records fee, sign an Authorization allowing for the release of records, or present me with a Court Order requiring that the records be released. In either event, I will provide a complete copy of my records to both members of the couple, or to all adult members of the family upon receipt of the Authorization or Court Order, and payment of the records fee.

I have determined that a reasonable, cost-based fee for providing a copy of your records will be $30.00 for files that are less than 100 pages. For any file that is more than 100 pages, the fee will be $60.00. The actual cost of shipping or mailing will be extra. Generally, I am not required to provide copies of requested records until the records fee is paid.

PLAN FOR PRACTICE IN CASE OF DEATH OR INCAPACITY

In the event of my death or incapacity, I have made arrangements for another psychotherapist to take over my practice, assume control of my records, meet with clients, make referrals to other providers, as appropriate, and take all reasonable steps to manage the practice for the benefits of my clients. By your signature below, you authorize my designee to contact you directly and use or disclose your confidential mental health information and records for the stated purpose.

LITIGATION POLICIES AND FEES FOR COURT-RELATED SERVICES

I became a therapist based on a genuine desire to help people and families be healthy both individually and as a whole. I do not find it therapeutically helpful in most cases for me to be involved in any way in client litigation. This is especially true regarding psychotherapy for children and adolescents due to the need for minors to trust the safety and privacy of their therapeutic relationship. If during the course of therapy, you become involved in any legal proceeding including but not limited to divorce, custody dispute, or personal injury suit, you agree that you nor your attorneys, nor anyone acting on your behalf will subpoena records from my office or subpoena me to testify in court, in a deposition, or in any legal proceeding. By your signature below, you acknowledge your understanding of this litigation policy and you agree to abide by it.

I will comply with lawfully issued subpoenas. **My hourly charge for all time related to court cases or litigation is $250**. You also agree by your signature below to make the required payment for the time I must spend dealing with your litigation. If I am subpoenaed to provide records or testimony in violation of this agreement and against my stated wishes, you also agree to pay for all my professional time, including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, and time spent testifying in court or deposition **regardless of which party issued the subpoena or requires me to testify**.

If I am required to testify in court or give a deposition in Bexar County, I will require a retainer in the amount of $1500 (6 hours at $250 per hour), which will include preparation time, travel time (door-to-door), and attendance at any legal proceeding. If I am required to testify in court or give a deposition outside Bexar County, I will require a retainer in the amount of $2000 per day (8 hours at $250 per hour), which will include preparation time, travel time (door-to-door), and attendance at any legal proceeding. By your signature below, you agree to pay the applicable retainer no later than 48 hours prior to the litigation event.

If the testimony or deposition exceeds 6 hours in Bexar County or 8 hours outside Bexar County, your credit card on file will be charged $250 per hour for every hour spent at any legal proceeding, including court or deposition. By your signature below, you agree that I will issue an itemized statement showing the breakdown of time and you further

agree to that the amount of the invoice can be charged to the credit card on file. When I go to court or give a deposition, I have to clear my schedule and not see other clients so there is a 48-hour cancellation policy for court and depositions. For example, if the court appearance or deposition is scheduled for a Monday, I must be notified of any cancellation by Noon on the Thursday before. Any cancellations that occur within that 48-hour time frame are **NON-REFUNDABLE**. I will accept credit card, money order or cashier's check for payment of fees related to court appearances or deposition. **NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES**. All payments are due 48 hours prior to the scheduled court appearance or deposition. By your signature below, you expressly authorize me to charge the credit card on file for any fees related to litigation and court appearances unless you notify me that you intend to make payment by cash, money order or cashier's check. Finally, if I am subpoenaed to provide records or testimony in violation of this agreement and against my stated wishes, I reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers.

I will NOT perform social studies or custody evaluations. I will NOT provide recommendations regarding possession, custody, access to or visitation with minor children. I will NOT provide legal advice. I will NOT provide medication or medical advice. These services are not within the scope of my practice.

If, alternatively, your therapy with me is court-ordered, you acknowledge and accept that our therapeutic relationship will be potentially subject to subpoenas for records and/or testimony depending on the nature of the court's order. In addition, you recognize and accept all of the above fees for any court involvement required of me in your case. Prior to accepting a court-order therapy case, I reserve the right to interview involved parties, potentially including attorneys and other professionals, to confirm my ability and willingness to provide the services ordered by the court. Time required for these initial interviews is billed at my court-ordered clinical rate of $175 per hour. If I am unable or otherwise decline to take the court-ordered case, I will provide referrals to other professionals for consideration.

COMPLAINTS

As an independent contractor with ICFE, I do not have a supervising employer. However, I invite and strongly encourage clients with any concerns or complaints to talk with me directly. I will make every effort to address the issues professionally and collaboratively with you. Clients who choose to file a complaint against me for violations of state laws and regulations or my professional ethics code should contact the Texas Behavioral Health Executive Council, Attn: Texas State Board of Professional Counselor, 333 Guadalupe St., Ste. 3-900, Austin, Texas 78701. Telephone: 1-800-821-3205, or online: http://www.bhec.texas.gov/wp-content/uploads/2020/07/BHEC-Complaint-Form.pdf. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at: OCRMail@hhs.gov.

My/Our signatures below confirm the following:

- I have received, have read (or have had read to me), and understand this Therapy Services Information and Informed Consent Form.
- I provide my informed consent for psychotherapy with S. Renee Turner, Ph.D, LPC-S.
- I understand that no promises or guarantees have been made to me as to the results of psychotherapy.
- I understand and agree to pay the session fee in full at each session unless prior clear written agreement has been made.
- I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel with 24 hours' notice or do not show up, I will be charged the full fee for that appointment and I agree to pay that fee.
- I understand that if I experience a mental health or a medical emergency, I will call 9-1-1 or go to the nearest emergency room for treatment.
- I have read and understand Dr. Turner's Litigation Policy and agree to pay the stated fees if I choose to involve him/her in my litigation or court case.

I have read this Agreement carefully. I understand the terms of this Agreement and I agree to comply with them. I understand that this Agreement is a contract between me and Dr. Turner and may be legally enforced as a written contract. I agree that this Agreement will stay in effect until I revoke it in writing and I understand that any written revocation must be dated after the date of this Agreement and must be provided to Dr. Turner. I agree that a copy of this Agreement has the same force and effect as the original.

Signed **(Client/Minor Client Guardian)** **Date**

Signed **(Client/Minor Client Guardian)** **Date**

Signed **(S. Renee Turner, Ph.D., LPCT)** **Date**

CONSENT FOR COMMUNICATIONS

As per the Notice of Privacy Practice, you have the right to request that I only communicate with you about your health information in a certain way or at a certain location. Please indicate where you would like to be contacted:

I prefer to be contacted by (select all that apply): O Phone O Email O Texting O Mail

I prefer to be called and/or texted at the following number:_____

I O DO O DO NOT want messages to be left at this number.

Please only call at these times: _____

I prefer emails to be sent to: _____

I prefer texts to be sent to: _____

I prefer mail to be sent to: _____

Specific instructions for calls, texts, emails, or other communication: _____

_____

Email, Texting, Online Platforms, and Applications

Your protected health information must be kept private and secure according to federal and state laws and professional ethics codes. Email and texting (as well as some online platforms and applications) are convenient ways to communicate for treatment purposes (such as discussing your current symptoms or concerns) and administrative purposes (such as appointment scheduling and billing). Reasonable means to protect the security and confidentiality of communications via email, texting, online platforms, and applications will be taken. **However, it is impossible to guarantee the security and confidentiality of communication via email, texting, online platforms, and applications.** Should confidential information be improperly disclosed, through no fault of mine or other ICFE clinicians, I am not liable for such disclosures.

Potential risks of communicating by email or text may include:

- Mis-delivery of emails or texts to an incorrectly typed address or number.
- Email and online accounts and phones can be hacked.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email, texts, and online platform or application data may exist even after the sender or the recipient has deleted his/her copy.
- Employers and on-line services have a right to archive and inspect emails, texts, online communications and application data transmitted through their systems.
- Information sent via emails, texts, online platforms, and applications can be intercepted, altered, forwarded, or used without authorization or detection.
- Emails, online platforms, and applications can be used to introduce viruses into computer systems.
- Emails, texts, and online platform and application data can be used as evidence in court.

All emails and texts to or from clients concerning diagnosis or treatment will be filed as part of the patient record. Since the information will be considered part of the record, other individuals authorized to access the record will also have access to those emails. Note that all email may be retained in the record of the system sending the email.

COMMUNICATION VIA EMAIL, TEXT, ONLINE PLATFORM, OR APPLICATION SHOULD NOT BE USED FOR MEDICAL EMERGENCIES.

You have the option of choosing whether to communicate with me via email, texting, online platforms and/or applications and what information you wish to communicate. **You do not have to consent to communication via email, texting, online platforms, or applications** and communication can be handled in person or via phone call or mail. You may revoke any permission at any time in writing.

By consenting to communicate through email, text, online platform or application, you also agree to the following responsibilities:

- If you send a communication that requires or invites a response, and one is not given within a reasonable time frame, it is your responsibility to notify me that the communication was not received. You cannot assume that because it was not returned that it was received.
- It is your responsibility to schedule, confirm, reschedule, or cancel appointments.
- To the extent possible you should NOT use email, texting, online platforms, or applications to make disclosures about sensitive medical information such as: mental health treatment, drug, alcohol or substance abuse, information related to AIDS and HIV, and genetic information.
- It is your responsibility to inform me of any changes to your communication preferences including changes in mailing address, phone number, email address, or online account usernames.

Email: I O DO O DO NOT consent to use **email** for

O Administrative Purposes and/or O Treatment purposes.

Other Conditions for **emailing**:_____

Texting: I O DO O DO NOT consent to use **texting** for Administrative Purposes.

***Note that Dr. Turner will not engage in text communication related to treatment issues. Text communication from Dr. Turner is restricted to scheduling, logistical and other administrative purposes only.**

Other Conditions for **texting**:_____

Social Media

Requests to connect from current or former clients on social networking sites, such as Facebook, LinkedIn, Twitter, Pinterest, Google+ or other sites or apps, will not be accepted. Adding clients as friends on these sites and/or communicating via such sites is likely to compromise privacy and confidentiality. Please do not communicate with me via any social networking sites.

The ICFE has a professional Facebook page at www.Facebook.com/pages/Institute-for-Couple-and-Family-Enhancement. This account used to share general information related to mental health, parenting, romantic relationships, and couple or family therapy. If you choose to "like" our Facebook page we assume that you are making an informed decision about how this may compromise your confidentiality. The fan list on the ICFE Facebook page is public information and easily accessed by anyone on the internet. The vast majority of our followers are not clients; however, there is a small risk that you could be identified as a client simply based on your decision to follow our page.

Business Review Sites

I may have listings on Google Place, Yelp, or other similar online services which include options for users to rate their providers and add reviews. These listings are not requests for testimonials, ratings, or endorsement from you as a client. You have a right to express yourself on any site you wish. But due to confidentiality laws, I cannot respond to any review on any site whether it is positive or negative. And like blog comments and other online communications, there are privacy risks.

Please sign below to confirm your acknowledgements of the risk or text, email, and other communication tools, and your consent for me to communicate with you in the means you indicated above.

_____ _____

Client Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Client/Patient

_____ _____

Minor Signature (if applicable) Date