RYAN PARKER, LCSW
Licensed Clinical Social Worker
4111 Medical Parkway, Suite 201
Austin, Texas 78756
(512) 387-7108

OFFICE POLICIES AND CONSENT FOR TREATMENT

THERAPY SERVICES: Psychotherapy is a process that provides you (and/or your child) with an opportunity to examine more deeply the problems with which you (and/or your child) are struggling, and it may lead to important changes. Although most people who engage in psychotherapy benefit from the process, there are no guarantees. Progress in psychotherapy may vary depending on the particular problems being addressed, and can depend on such factors as motivation and effort, as well as life circumstances, such as interactions with family and friends. To be successful, psychotherapy requires a joint effort between the patient(s) and the therapist.

Psychotherapy can have benefits and risks. Since therapy often involves addressing difficult aspects of your (and/or your child's) life, you (and/or your child) may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Therapy may have an impact on you (and/or your child's) current relationships, involve psychiatric consultation and may not lead to improvement or anticipated results. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to improved daily functioning, better relationships, solutions to specific problems, and significant reductions in feelings of distress.

The first few sessions will involve an evaluation of your (and/or your child's) needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise.

SESSIONS AND CANCELLATION POLICIES: Once we agree on a regular time or times to meet during the week, I will reserve those hours for you. I will give you advanced notice of any planned absences. If you need to cancel a session, please notify me immediately. I will not charge for a session cancelled with 48 hours notice. For sessions cancelled with less than 48 hours notice, I will try to reschedule at a mutually agreeable time. If we cannot reschedule prior to the next regularly scheduled appointment time, then you will be required to pay for the cancelled session.

PAYMENT FOR SERVICES: You will be expected to pay the agreed upon fee for each session at the end of each session unless other arrangements have been made. Telephone conversations lasting less than 10 minutes will not be billed. However, longer telephone conversations and time spent performing other services that you request of me will be pro-rated at our agreed-upon rate for psychotherapy services. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments.

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CONTACT AND EMERGENCY PROCEDURES: I am often not immediately available by telephone, since I do not answer the phone while I am with patients. When I am unavailable, my telephone is answered by voicemail. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of times when you are available. If I will be unavailable for an extended length of time, I will provide you with the name of a colleague to contact, if necessary. If an emergency situation arises, please call me and indicate it clearly in your message. If you ever feel that you need immediate assistance, call 911 or contact your physician or the nearest emergency room and ask for the mental health professional on call.

PROFESSIONAL RECORDS: The laws and standards of my profession require that I keep treatment records. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your (or your child's) records, I recommend that you review them in my presence so that we can discuss the contents. Please note that you will be charged an appropriate fee for any professional time spent in responding to information requests. You are entitled to receive a copy of your (or your child's) records unless I believe that seeing them would endanger the life or physical safety of you (or your child), or another person. In such a case, I would be happy to send your (or your child's) records or a summary of those records to a mental health professional of your choice.

CONFIDENTIALITY: Privacy is an extremely important part of psychotherapy. Everything that is communicated between patient and therapist is confidential and legally privileged. The only time information will be released to a third party is if you have given me written permission to do so. In the following situations, however, I am legally mandated by law to disclose information without either your consent or authorization:

(1) If there is an emergency situation in which I believe that you (or your child) may be a danger to yourself (him/herself), or that you (or your child) are gravely disabled
(2) If you (or your child) communicate to me a serious threat of violence against someone
(3) If I have reasonable suspicion that a child or an elder/dependent adult is being abused
(4) If you file a complaint or lawsuit against me, I may need to disclose relevant information in order to defend myself
(5) If a court or government agency requests information, I may be required to provide it

If any such situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

I may occasionally find it helpful to consult other professionals about my cases. While the consultant is also legally bound to keep the information confidential, I make every effort to avoid revealing the identity of my patient.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

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PATIENT RIGHTS: HIPAA provides you with several new or expanded rights with regard to your (or your child's) Clinical Records and disclosures of protected health information. These rights include requesting that I amend your (or your child's) record; requesting restrictions on what information from your (or your child's) Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

TERMINATION OF TREATMENT: You have the right to terminate your (or your child's) treatment at any time, as participation is voluntary. In such case, we will set a date for termination, review the progress achieved thus far, identify any remaining issues and identify appropriate referral sources. I may also terminate treatment, if I believe that psychotherapy is contraindicated or if an issue emerges that is beyond the scope of my competence. In such cases, such concerns would be fully discussed with you prior to terminating treatment, and an appropriate referral would be provided, if applicable.

I have read, understand, and agree to comply with the policies described above, and hereby consent to treatment. I agree to abide by the terms of this agreement and acknowledge that it is my responsibility to pay for services rendered by Ryan Parker, LCSW. I understand the limits to confidentiality and the office policies regarding fee payment and cancellations. I understand that this consent form covers me and/or my child while in treatment. In addition, I certify that I have been given copies of this document and the HIPAA Notice of Privacy Practices.

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Patient Name (Print) **Patient Signature** **Date**

If patient is a minor:

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Parent/Caregiver's Name (Print) **Parent/Caregiver's Signature** **Date**

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Parent/Caregiver's Name (Print) **Parent/Caregiver's Signature** **Date**