**Denise Childress, MS, LMFT, PLLC**

**2500 South Broadway, Suite 320**

**Edmond, OK 73013**

**CONFIDENTIALITY**

Confidentiality means that Denise Childress MS, LMFT, PLLC has a responsibility to safeguard information obtained during counseling. All identifying information about your assessment and treatment is kept confidential, except as mandated by law. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your consent. In such situations, Denise Childress MS, LMFT, PLLC is not required to inform you of her actions. Please note the following exceptions to confidentiality:

* Confidentiality does not apply to cases of suspected abuse/neglect of children or of vulnerable adults.
* Confidentiality does not apply to cases of potential harm to self or others.
* A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
* Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
* Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without minor’s consent, of the treatment needed by or given to the minor.

Insurance and managed care companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)**

Denise Childress MS, LMFT is required by law to protect the privacy of your health information. Although your counseling record is the physical property of Denise Childress MS, LMFT the information contained in your health record belongs to you.

You have the right to:

* Request a restriction on certain uses and disclosures of your information.
* Obtain an accounting of disclosures of your health information as provided by law.
* Request communications of your health care information by alternative means or locations
* Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**THE BENEFITS OF COUNSELING**

One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with marital, family, and other interpersonal relationships, and /or a greater understanding of personal goals and values.

**THE RISKS OF COUSNELING**

There are certain risks involved in counseling. You may experience a variety of negative emotions during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended. The greatest risk of counseling is that it may not by itself resolve your concerns. Psychotherapy is a collaborative process and the progress you make will depend in large measure upon your investment in the process.

**EMERGENCY SERVICES**

Denise Childress, MS, LMFT, PLLC is not an emergency service. If a situation for which the client or their guardian feels immediate attention is necessary, and I am unable to return your call within a reasonable amount of time, the client or guardian understands that they are to contact 911, go to the nearest emergency room for those services, contact the Crisis Center at (405) 522-8100, or call the Suicide Prevention Hotline at 1-800- 784-2433.

**COST OF SERVICE**

The cost of service is ­$150.00 per session.

**COST OF SERVICE FOR COURT/RECORDS –** Any time spent outside of therapy for gathering information for attorneys, travel, and appearance in court will be charged at the rate of $250.00 per hour. \_\_\_\_\_\_\_\_\_\_ please initial.

**PAYMENT OF FEES**

All fees should be paid at the time the service is rendered.

**CANCELLATIONS**

Cancellations must be made twenty-four hours in advance to avoid charge. Missed appointments will be charged the regular fee.

**NSF CHECKS AND REJECTED CREDIT CARD CHARGES**

There will be a $25 charge for each NSF check or credit card rejection.

**WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING**

I have read and accept this agreement and herewith consent to counseling/psychotherapy/ treatment with Denise Childress MS, LMFT, PLLC.

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Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Parent or Guardian Date

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Denise Childress MS, LMFT, PLLC. Date

**Denise Childress, MS, LMFT, PLLC**

**2500 South Broadway, Suite 320**

**Edmond, OK 73013**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Denise Childress, MS, LMFT, PLLC to use my credit card details for charges incurred for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Patient Name*), which includes missed session fees.

This agreement will be in effect until I revoke this agreement in writing to:

Denise Childress, MS, LMFT, PLLC

2500 South Broadway, Suite 320, Edmond, OK 73013

I understand that if this agreement is not paid as agreed it will be turned over for outside collections and all collection agency’s fees and attorney’s fees will become patient responsibility.

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Responsible Party Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Circle one*) Visa / MasterCard / Discover

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Credit Card Number

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Cardholder Name as Appears on Card

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Billing Address Associated with Card City State Zip Code

A $3.00 fee is added to all credit card charges. \_\_\_\_\_\_\_\_

Initial please