

# BRITTANI PERSHA COUNSELING

## *Child and Family Counseling Services*

### **Information and Informed Consent for Counseling Services**

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

#### **THERAPY SERVICES**

Counseling is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a recommended treatment plan. We work collaboratively with our clients and encourage your thoughts and feedback. It is important for you and your clinician to maintain consistent communication of how you are feeling about the therapy process and monitor your goals. Therapy is shown to be most effective with clients take an active role in meeting these goals.

#### **APPOINTMENTS**

Counseling sessions are 50 minutes long. We usually recommend initially scheduling weekly therapy sessions, however sessions will be scheduled according to specific client needs. If a client is late to a session, the session will still end at the scheduled time.

#### **CANCELLATION POLICY**

If you need to cancel or reschedule an appointment, We request you provide 24 hours notice. If you do not provide 24 hours cancellation notice you will be charged a \$100 cancellation fee. With that being said, allowances may be made at therapist's discretion due to emergencies or sudden illnesses, as long as client contacts therapist within 24 hours of missed session. It is also important to not that insurance companies do not provide reimbursement for cancelled sessions, thus, you will be responsible for the fee as described above.

#### **PAYMENT AND PROFESSIONAL FEES**

Brittani L. Persha, LCSW Rates:

Initial Assessment- \$130      50 minute Therapy Sessions- \$125

Rodrigo Cañedo, LMSW Rates:

Initial Assessment- \$90            50 Minute Therapy Sessions- \$90

Payment is required at the time services are rendered. Payments may be made by cash or major credit card (Visa or MC); checks are not an acceptable form of payment. We reserve the right to use an attorney or collection agency to secure payment for unpaid balances. You are responsible for any services not covered by insurance. It is our practice to charge \$35 to complete forms, write letters, or print/copy client records.

## **RECORDS**

We are required to maintain records of our work together. These include a clinical diagnosis, a brief synopsis of our sessions, and any observations or plans for future sessions. These records will not be released without your written consent except in situations described under confidentiality. If you are going to file for insurance reimbursement, insurance companies require we send them a diagnosis along with dates of services. Sometimes insurance companies request additional notes from our sessions.

## **CONTACTING ME**

We can be reached at (713) 364-8645. We are not always immediately available by telephone, but check voicemails frequently and return all calls within 24 hours, Monday-Friday.

## **EMAIL & TEXT MESSAGING**

Email and text messaging are not confidential means of communication. Therefore, no personal or clinical issues will be discussed via these forms of communication. However, email and text messaging are convenient ways to handle administrative issues like scheduling and reminding of appointment times. Please indicate on the Client Information Form if you would like to consent to use of these forms of communication for administrative issues.

## **PARENTS & MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern.

## **COUPLES COUNSELING**

In couples counseling the couple is considered to be the client. In order to maintain the integrity of the counseling relationship with both members of the couple and to avoid conflicts of interest anything told to the therapist individually will not be held as confidential. Information may be shared with the other partner at the therapist discretion. If at any point, you feel that you need to share information that must be kept from your partner, you can request a referral to another counselor for individual therapy.

## **CONFIDENTIALITY**

In general, the privacy of all communications between a patient and therapist is protected by law. It is your right that all communication between yourself and your therapist be completely private with the following few exceptions:

- You are considered a danger to yourself or others.

Brittani Persha Counseling  
14760 Memorial Dr., Ste. 207 Houston, TX 77079  
Office: (713) 364-8645 Fax: (832) 917-0076  
[www.brittanipershacounseling.com](http://www.brittanipershacounseling.com)

- A court subpoenas your records.
- You are a minor, elderly or disabled and I believe you are a victim of abuse, CPS must be informed.
- You have perpetrated abuse against a minor, elderly or disabled person.
- You file a suit against Brittani L. Persha, LCSW or Rodrigo Cañedo, LMSW.
- You use insurance for payment, and the insurance requests information about your case.
- You are under 18 years of age and your parent or legal guardian requests information that we consider necessary for them to support your treatment.

By your signature below, you are indicating that you have read this statement of Information and Informed Consent for Counseling Services and consent to all of the above. Further, your signature below indicates that you have received, read and agreed to the information discussed in the Notice of Privacy Practices.

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

## Credit Card Authorization

I, \_\_\_\_\_, hereby authorize Brittani Persha Counseling to bill my credit card for:

1. Recurring charges (on-going therapy sessions) at the agreed upon fee or insurance contracted rate for professional services.
2. Balances or charges not paid by me or insurance within 90 days from the date of services.
3. Fees or charges for other services or for missed appointments as described in the Information and Informed Consent for Counseling Services Form.

This form will be securely stored in the client's clinical file and may be updated upon request at any time.

I understand that I may revoke the agreement at any time by providing a request in writing.

Client's Name: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_

Cardholder's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please circle card type:                      VISA                      MASTER CARD

Account #: \_\_\_\_\_

CVV Code (3-digit code on the back of the card): \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_