

Human Connections Counseling Services
Mark Felber, M.S., LPC, SAP, LCDC, CSAT, CMAT, CP
Plano, Texas
Office: (214) 796-2323
www.MarriageCPR.com

Information and Consent

I am pleased that you have selected me as your therapist. This document is designed to inform you about my background and to insure that you understand our professional relationship.

I hold a Master of Science in Counseling from Texas A & M University and have worked in the field of counseling since 1995. I am licensed by the state of Texas as a Professional Counselor (L.P.C.) and Licensed Chemical Dependency Counselor (L.C.D.C.). My counseling practice includes work with individuals, adolescents, adults, couples, and groups.

Nature of Counseling:

I only accept clients in my practice whom I believe have the capacity to resolve their own problems with my assistance. I believe that as people become more accepting of themselves, and more aware of their choices, they are more capable of finding contentment in their lives. Some clients need only a few therapy sessions to achieve their goals, while others may require months or even years of therapy. Please feel free at any time to bring to my attention any changes you would like to see in how your counseling proceeds. Your input is an essential part of your therapy process. If therapy is successful, you will feel that you are able to face life's daily challenges on your own, with the knowledge that future counseling support will be available if needed.

It is important for you to realize that we have a professional relationship and not a personal relationship. Our contact will be limited to the therapy sessions you have with me. You will be best served if our relationship remains strictly professional and our sessions concentrate exclusively on your concerns.

Risks of Therapy:

While benefits are expected from counseling, specific results are not guaranteed. Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for life-style choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

Referrals:

If, at any time, you should decide that your counseling sessions are not meeting your needs, please let me know so that we can talk about it, and review together the goals that we have set for your therapy. If you are dissatisfied, I will provide you with referrals to other therapists.

Fee Policy:

My fees are the following:

- \$ 150.00 50 minute in-office session (Individual or Couple, or Family)
- \$ 150.00 50 minute telephone counseling session
- \$ 150.00 Per hour for reports
- \$ 150.00 Per hour for consultations on your behalf

The fee for each session will be due and must be paid at the conclusion of each session. Telephone counseling fees must be paid in advance of each session. Cash or personal checks are accepted for payment.

In the event that your check is returned for insufficient funds, you will be expected to pay for the amount of the session plus any fee that my bank charges me for the returned check. If you have two checks returned for insufficient funds, you will be expected to pay for sessions in cash only.

Cancellation Policy:

In the event that you will not be able to keep an appointment, you must notify me 24 hours in advance, or you will be required to pay the entire fee for the session. My voice mail may be reached 24 hours a day, and the date and time of phone calls are recorded. Consistently late cancellations or missed appointments may be cause for termination.

Court Testimony:

Should I be requested to participate in legal proceedings on the client's behalf, my fee is \$150.00 per hour for travel time to and from court. My fee is \$200.00 per hour for my time at the courthouse. Should I be called to testify, I require a minimum prepayment of four (4) hours of court time, or \$800.00. If this prepayment exceeds the final total fee, the excess will be refunded.

Policy on Insurance Reimbursement:

If you have medical insurance, which provides coverage for mental health counseling, I am anxious to help you receive your maximum allowable benefits. With the exception of

Medicaid for clients who cannot afford psychotherapy services, I do not accept assignments of benefits (get reimbursed from insurance companies), nor do I participate in managed care insurance plans (**HMO's** and **PPO's**). I have found that the extraordinary amount of paperwork required takes away from your care. Moreover, insurance coverage only covers those issues considered a "medical necessity," which is defined as helping someone get to a *basic* level of functioning. Anything more is considered beyond medical necessity and not the responsibility of the insurance carrier. Such therapy focuses on symptoms while ignoring the underlying human issues that create them. It is like taking only enough antibiotics to diminish the symptoms of an infection. The infection comes back.

Thus, insurance coverage is now covering mostly crisis oriented, short-term therapy limited to problems that endanger life and basic welfare. People who rely on a crises oriented system are in danger of having the same problems repeatedly, despite seeking professional help. Instead, I deliver treatment that goes beyond crises and symptoms. This means seeing people enough to get beyond the surface. It means realizing that symptoms are attempts to deal with a problem, not the problem itself. Part of good therapy is about taking enough time. I offer that choice to my clients, and give them the opportunity to maintain their privacy since their personal information won't be floating around in a number of impersonal, managed care bureaucratic organizations where inappropriate electronic access to their files is always a risk.

I will, however, be happy to help you process your insurance claim form for your reimbursement. A completed insurance claim form must accompany any such request at each visit. You are responsible for mailing it to the insurance company and tracking your reimbursement.

I will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. I am not a party to that contract.
2. My fee is generally considered to fall within the acceptable range of most companies, called "Usual, Customary, and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from me in order to process your claim, I will need to receive my normal hourly fee from you for this service.
5. It is your responsibility to contact your company regarding the above to find out about their reimbursement policies.

Requests for Records:

Should you request a copy of our counseling records, or give permission to another person or organization to request a copy of your counseling records, this office will submit the requested information for a fee of \$20.00, due in advance. The fee for a written summary of your record is \$100.00, due in advance. If your insurance company is requesting the information, you may be able to obtain reimbursement from them by submitting a receipt for service from my office.

Records and Confidentiality:

All of our communications will become part of the clinical record that is accessible to you on request. I will keep confidential anything you say to me, with the following exceptions:

- (1) when you authorize release of your records in writing;
- (2) when the possessory conservator of a child requests access to the child's records, or requests consultation with the therapist;
- (3) when a court of law subpoenas your record or a therapist's testimony;
- (4) when there is reasonable concern that harm may come to you or others (i.e., suicide, homicide, child physical/sexual abuse, and neglect);
- (5) certain client information may be given (as required) to any entity responsible for the payment or collection of client fees, and/or
- (6) information about your case may be shared within the professional supervision process.

Ending Treatment:

As a client, you are in complete control and may end our counseling relationship at any time. If you should decide that your therapy is not meeting your needs, please let me know so that we can talk about and review together the goals that we have agreed upon for your therapy. Similarly, I will let you know if it appears to me that your therapy is no longer meeting your needs; in which case I will explain my perspectives as well as alternatives open to you for your continued improvement. If you decide to withdraw from treatment, I ask that you provide a minimum of a seven- day advance notice so that we can both plan responsibly for any outstanding issues. Ending therapy is a therapeutic issue. If you are thinking about ending therapy, please raise this issue during a therapy session. Leaving and being left are events with such an impact on people's lives that as much time as possible should be allowed for reactions to be examined.

Client Emergencies:

In the unlikely event that I believe you are a danger to yourself or others, by signing the consent you are releasing me to contact either the persons listed as emergency contacts or someone else to provide assistance through the crises situation. This could include the intended victim. In the event that you experience a crises necessitating immediate care and I cannot be reached, the following numbers are provided. Please write them down and put them where you can find them in an emergency.

Parkland Psychiatric Emergency Room—(214)—590-8761
Contact Dallas—(972)—233-2233
Crises Center—(214)—828-1000

In the event of an emergency, I authorize my therapist to contact the following persons.

Contact # 1 address:

Contact # 2 address:

Home phone: _____

Home phone: _____

Bus. phone: _____

Bus. phone: _____

This consent is subject to revocation by the undersigned client at any time, except to the extent that the action has already been taken in reliance on it. Specifications of the date, event, or condition upon which this consent expires:

_____.

THERAPIST/CLIENT CONTRACT:

In return for a fee of \$_____ per session, I agree to provide counseling services for you. By your signature below, you are indicating that you agree to this fee. This fee amount may be re-evaluated on a periodic basis. In addition, you are indicating that you have read and understood this document, and/or that any questions you have had about this statement have been answered to your satisfaction.

Client Date

Therapist Date

Client Date

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I _____ understand and agree to be a self-pay cash basis client only. No insurance will be filed at this time, under this agreement. If insurance is obtained at a later date, Mark Felber's office will file claims from that date forward. Any past visits will have to be filed by you, the client. Mark Felber's office will not be held responsible for filing any previous claims.

Signature _____

Signature _____

Date _____