

CTPC | CENTRAL TEXAS
PROFESSIONAL COUNSELING

542 Comal Avenue, New Braunfels, TX
(830) 629-2300

TexasProfessionalCounseling.com

CHERYL E. DUKE MA, NCC, LPC

Consent for Treatment of Minor/s & Others

I _____ give my consent that **Cheryl E. Duke, MA, NCC, LPC**
will be conducting psychotherapy with _____.

My relationship to the client (parent, guardian, etc.): _____

I have been notified that the holder of the privilege is (parent, guardian, etc.):

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Policies & Procedures form, which I have read and signed. In the case of a minor special sensitivity may be required in releasing information about certain topics. I will accept **Cheryl E. Duke, MA, NCC, LPC's** judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well being.

Name (print) Relationship Signature Date

Name (print) Relationship Signature Date

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CHERYL E. DUKE MA, NCC, LPC

Informed Consent to Assume Responsibility for Payment for Psychotherapy Services

I, _____, agree to pay for psychotherapy services and other clinical services for _____ according to the fee agreement between the therapist and the client.

I understand the following terms apply to this agreement:

- Payment will be made at the time of service
- The fee for psychotherapy, psychological testing and interpretation, consultation, letter or report writing or other clinical services is \$90.00 per 60 minute session, unless otherwise specified. For more details, see Policies & Procedures form.
- Please inform the therapist ahead of time, or as soon as you know, if there are changes in your ability or willingness to pay.
- Services will be terminated if timely payment is not made as agreed to by this consent.
- Consent to assume financial responsibility for these services does not entitle the third party payer access to confidential information unless agreed in writing by the above named patient.
- Upon your request and upon obtaining client's written permission, if appropriate, you will be provided with a bill, which is suitable for presenting to your insurance carrier for possible reimbursement. Not all conditions are reimbursable.
- This agreement supplements previous informed consents.

Signature of Client: *Date*

Signature of Payee: *Date*

CHERYL E. DUKE MA, NCC, LPC

Waiver of Right to Client Information and Paperwork

I (parent/guardian), _____, give up my right to access
(client) _____'s information shared within session and clinical records without the
express written or verbal consent of client.

Client's parent or guardian

Date

As a parent myself, I am aware that the level of confidentiality between me and your son or daughter may seem excessive and waiving your legal rights to his or her information and paperwork may be concerning. However, I will provide general information regarding our therapeutic progress with your son or daughter's approval. Furthermore, if I feel it is important for you to know certain information in order to make sure that your son or daughter and people around him or her are safe, I will disclose information quickly and willingly upon discussing the disclosure with your son or daughter if possible. If I think it is appropriate, I will involve you if I feel that there is a high risk that your son or daughter will seriously harm themselves or another/others. Moreover, if you detect negative changes in their behavior and please contact me; I will be more than happy to listen and, if given consent from my client, provide some insight into these changes. I believe that the therapeutic process can only be successful if my professional relationship with your son or daughter is protected by complete confidentiality and you remain involved, accepting of the therapeutic relationship, and open to participating when your son or daughter feels it will enhance their treatment.

Cheryl E. Duke, MA, NCC, LPC

Minors in Therapy:

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request a written agreement from your parents or guardians indicating that they consent to **give up** access to such information and/or to your records. If they agree, I will provide them only with general information about our work together, subject to your approval, or if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

Cheryl E. Duke, MA, NCC, LPC