LISA POWELL, PHD, LMFT-S, LPC-S
5601 DEMOCRACY DR., SUITE 135
PLANO, TX 75024
(972) 765-8710

Informed Consent

I acknowledge I have read, (or have had read to me), received, and understand the Professional Disclosure Statement and the Informed Consent. I have had all my questions answered fully.

I do hereby seek and consent to take part in treatment with Lisa Powell, PhD, LMFT-S, LPC-S. I understand that developing goals and a treatment plan with this counselor and regularly reviewing our work will be in my best interest. I agree to play an active role in the process.

I understand that no promises have been made or will be made as to results of any treatment or any procedures provided by the counselor.

I understand that Dr. Powell will maintain my confidentiality with the exception of the ethical limits of confidentiality set forth in the Professional Disclosure Statement. I understand that Dr. Powell may consult with colleagues in reference to my case in order to better serve me.

I am aware that Dr. Powell has a therapy dog, Luke, who is sometimes present for counseling sessions. I can schedule my sessions on days when Luke is not present, or specifically with Luke if I desire.

_____ I am comfortable having a therapy dog in my sessions if my appointment is scheduled on a day when he is in the office.

I am aware that confidentiality while using electronic communication cannot always be guaranteed. I understand that while Dr. Powell will take every precaution to assure my confidentiality while using electronic communication, this is no assurance that confidentiality can be maintained. Because of confidentiality concerns, Dr. Powell will not engage in communication via social media with any clients or families of clients. I give Dr. Powell permission to contact me via:

_____ Email
_____ Text messages
_____ Leave messages on voice mail when calling

I know I must call to reschedule or cancel an appointment at least 24 hours in advance. Dr. Powell has reserved my appointment time for me and has potentially turned away other clients in order to save my time for me. If I need to cancel with less than 24 hours notice, or fail to attend a session, I will be charged a $50 fee on my credit card kept

on file with Dr. Powell. Insurance will not cover missed appointments and this is my financial responsibility.

I am aware that I may stop treatment with this counselor at any time. I will still be financially responsible for payment for past scheduled sessions if payment is not current.

Court related fees: I understand that if Dr. Powell is subpoenaed, court ordered, or asked to testify in court, the standard rate is $225 per hour. This includes court prep, consultations with other professionals preparing for court, travel time, and court time. There will be a 4-hour minimum charge if she must appear in court. Any time above 4 hours will be charged at the $225 per hour rate. The fees are to be paid in full 48 hours in advance of the court appearance. Any additional fees incurred after payment will be due within 48 hours after the appearance in court.

My signature below confirms that I understand and agree with all these statements.

_____
Client signature Date

_____
Parent or guardian signature Date

Credit Card to be kept on file	
Name on card	
Credit Card Number	
Expiration date	
CVV code	
Zip code	

I have discussed these issues with the client, parent, or guardian of the client, or other representative. My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give me informed and wiling consent.

_____ Counselor signature

_____ Date

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HIPAA COMPLIANCE

The HIPAA notice describes how mental health information about you may be used and disclosed and how you can get access to this information. This Privacy Notice tells you about the rights you have concerning your mental health care records. You can look at this copy anytime to see what use is made of your health care records. And who gets to see them. A new government rule requires that we give you this Privacy Notice to sign.

The HIPAA Compliance notice is posted in the waiting room. If you would like a hard copy of the HIPAA Compliance information, please let your counselor know and a copy will be provided for you. Please review it carefully.

By signing below, you attest that you have read and have been made aware of your rights of confidentiality as a mental health consumer.

Client/Guardian printed name and relationship to the patient

Client/Guardian signed name and date