David Ashburner, MA, LPC, CSAT, CPTT, CHFP

InGearCounseling, PLLC

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Informed Consent Agreement

This document contains important information about counseling, my business policies, and me. Please read it carefully and note any questions you might have so that we can discuss them. Once you sign this form, it will constitute an agreement between us.

The following is an agreement entered into between David Ashburner, LPC, the therapist, and (print) ____, as client(s), on this date ______________________.

Counseling Approach

My method of counseling combines cognitive-behavioral therapy, family-systems therapy, solution-focused therapy, task-centered therapy, attachment theory, and group therapy, as well as other approaches that may fit a given client or couple. I take a positive approach to problems, assuming that people are resilient and have tremendous abilities to address their life situations. It is my role as a counselor to help you understand the dynamics of your situation and to help you use your particular strengths to address your issues.

Qualifications

- License
  - Licensed Professional Counselor (LPC) in the state of Texas

- Certifications and Training
  - Certified Sex Addiction Therapist (CSAT)
  - Certified Partner Trauma Therapist (CPTT)
  - Certified Multiple Addiction Therapist (CMAT)
  - Certified Hope and Freedom Practitioner (CHFP)
  - Fully trained in Eye Movement Desensitization and Reprocessing (EMDR)
  - Fully trained in Emotionally Focused Therapy (EFT)

- Degrees
  - Master of Arts in Professional Counseling, Argosy University Dallas
  - BS in Pharmacy, St. Louis College of Pharmacy
  - BS in General Studies, Southeast Missouri State University

Therapeutic Relationship

Our contact will be limited to psychotherapy sessions that you arrange through me. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. Office clerical personnel will only have enough information about you to schedule appointments, contact you, and facilitate collection of fees. It is my policy not to accept gifts from clients of more than a nominal value.

Audio/video recording is prohibited in the counseling session, unless expressly agreed to in writing between the therapist and the client. In all cases, the audio/video recording is part of the clinical record, and the property of the therapist.

Benefits and Risks of Treatment

Symptoms may worsen before they get better because psychotherapy may bring up unpleasant memories and emotions. I will facilitate your journey, supporting you as you move forward; however, you are the one who must do the work to get the results you desire. Your willingness to work hard and make a commitment to the therapeutic process is necessary for you to achieve and maintain the long-term results you want. The benefits of outpatient psychotherapy may include improved functioning in your personal and professional relationships, improved communication skills and a reduction in symptoms that led you to seek therapy in the first place.

Client Rights and Responsibilities

You may end our therapy relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my psychotherapy techniques or suggestions that you believe might be harmful. You agree to come to therapy free from the influences of drugs, including alcohol.

Referrals

Should you and/or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Method of Payment

Unless otherwise arranged in writing, the credit card information gathered on the Client Credit Card Authorization Form will be used to bill for services rendered or for missed appointments per the 24-hour cancellation policy.

Fees and Agreement

My fee for a 60-minute session is $175. The first 55 minutes (or close to that) will be counseling, and the last 5 minutes taking care of payment, next appointments, etc. This will allow me to run more on time and be respectful of your time and mine. Each part of a 10-minute block past 60 minutes will be prorated per 10 minutes. There are times where it may be well worth our time to spend a few more minutes and finish an important topic, or hold starting an important topic until the next session. At the beginning of each session let me know if there are any hot topics or issues you would like to cover in the session. This will help with time management and help you get the most out of your sessions.

- 60 minutes $175
- 90 minutes $262
- 120 minutes $350

24-hour cancellation policy: You will be billed in full for missed sessions unless you call 214-773-6201, at least 24 hours in advance, to cancel the appointment.

Miscellaneous Fees

- For each letter clients request being sent on their behalf, the fee will be determined by my hourly fee.
- Court appearance and/or testimony is billed at $200 per hour, with the minimum charge being $1,600 per day. In the event the therapist is required to be present at the court for additional days waiting for his testimony to be given, each day of waiting is charged at the same $1,600 per day. There is no charge for travel time for testimony given in the Texas counties of Dallas, Tarrant, Collin, Denton, or Rockwall. Expenses such as airfare, hotel, taxi, meals, etc. are the responsibility of the client and are in addition to the daily charges delineated above. In order for me to clear my schedule and plan on appearing in court, a non-refundable deposit of $1,600 must be paid one week (7 calendar days) in advance of the court appearance.

Unpaid Debts/Returned Checks

Payment is required when services are rendered. Unpaid debts will be turned over to a collection agency. Collection fees will be added to the client(s) bill. Returned check (i.e., insufficient funds, etc.) charge is $30.

Insurance Waiver and Agreement

This office does not file insurance claims, but a receipt will be provided. The client(s) understand that they are responsible to obtain any pre-certification for Intensives without the assistance of their therapist. The client(s) understand that verification of benefits or pre-certification of services does not guarantee that an insurance carrier will cover this type of outpatient intensive service, and the client agrees to pay at the time of service.

Records and Confidentiality

All of our communication becomes part of the clinical record. Records are the property of the therapist. By law and professional ethics, your sessions are strictly confidential. Generally, no information will be shared with anyone without your written permission. If you have seen another therapist or health care professional, it may be helpful for me to share information with them. If this is necessary, I will ask for your written permission to contact them.

Also, by law and professional ethics, here are several exceptions to this confidentiality policy:

- I determine that you are a danger to yourself or someone else
- You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person
- You disclose sexual contact with another mental health services provider
- I am ordered by the court to disclose information
- If there is a licensure board inquiry, I may be required to share information with the board
- If action is required to collect fees, then confidentiality may be breached through collection procedures
- I am otherwise required by law to disclose information

In the case of couples or family psychotherapy, I will keep confidential (within the limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to therapeutic progress.

Tips for getting more out of counseling

- You might want to come a few minutes early to allow for unforeseen traffic, catch your breath, collect your thoughts and prepare for your session.
- Come with a notebook to jot down key learnings, eureka moments, homework, and maybe to take notes.
- Cell phones: I will always try to remember to have my phone turned off and face down, so I am not distracted from our work together. You are shortchanging yourself if you do not turn your phone off (silent and no vibration) so that you can give yourself the benefit of your full attention. There may be exceptions where you may need to be available for a family emergency, but give yourself the gift of coming first for that 1 hour.
- If there are any hot topics or issues let me know at the beginning of the session. This will help with time management and help you get the most out of your sessions.

No Emergency Calls

This office does not take emergency calls. If you have an emergency, go to your nearest hospital emergency room or call 911.

Acknowledgment and Consent

By my/our signature(s), I/we agree to the terms and conditions outlined within this document. (Each participant is required to sign this agreement form.)

Client Name (Print) ____

Client Signature ____ Date __________________

Client Name (Print) ____

Client Signature ____ Date _________________

Client Credit Card Authorization Form

I authorize my therapist, David Ashburner LPC, of InGearCounseling PLLC, to keep my signature and card information in order to charge in-person therapy and/or teletherapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (testing, books, workbooks, and other materials, and/or fees), or for any appointments with my therapist that are not cancelled 24 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below for therapy services provided to:

____

Print Client's Name

____

Print spouse or partner's name (if applicable)

I understand that this authorization is valid until canceled in writing.

I agree to provide new card information when this card expires, is canceled, or is declined for any reason.

I agree that the card listed below may be charged in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services.

I agree that if I have any concerns or questions regarding charges to my account, I will contact my therapist, David Ashburner LPC, with InGearCounseling PLLC, for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed.

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above.

Cardholder Name (print):____

Relationship to client:____

Card Number: ____

Exp. Date: ___________

Security Code: __________

Billing Address:____

Zip Code: _____________________________

Cardholder Signature: ______________________________________ Date: ______________

Informed Consent for Telehealth Services

__Definition of Telehealth__: Telehealth, also referred to as telecounseling, involves the use of electronic technology to enable clinicians to connect with clients using live interactive video and/or audio communications without being in the same location. Telehealth includes the practice of psychological health care delivery, consultation, treatment, referral to resources, education, and the transfer of clinical data.

I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth.
2. I understand there are limitations to confidentiality when utilizing technology. Unlike face-to-face counseling, my counselor cannot guarantee the same degree of confidentiality since telehealth partially takes place in a space outside of my counselor's control (i.e. the internet and my physical location). This means I agree to take full responsibility for where I decide to initiate telehealth and how I will protect the confidentiality of my conversation. I understand that it is strongly recommended that I find a private location (i.e. inside my home or vehicle).
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that there are both risks and benefits to telehealth. The risks may include, but are not limited to, the possibility, despite reasonable efforts on the part of my counselor, that the transmission could be disrupted or distorted by technical failures.
5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/internet-/telephone- based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-centered health care facility in my immediate area.

__Payment for Telehealth Services__:
By signing this document, I agree that my credit card will be billed for my telehealth sessions, or for any appointments with my therapist that are not cancelled 24 hours before the scheduled appointment time. My credit card information will be provided on the Client Credit Card Authorization Form.

__Patient Consent to the Use of Telehealth__:
I/we have read and understand the information provided above regarding telehealth. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

Client Name (Print) ____

Client Signature ____ Date __________________

Client Name (Print) ____

Client Signature ____ Date ________________