PATHWAY COUNSELING CENTER

Waco, Texas

COUNSELING INFORMATION AND CONSENT

Thank you for selecting our Counseling Center. This consent form explains some important information about our counseling procedures. Your therapist is a licensed professional counselor and will review this information with you in your first session, at which time you will be asked if you understand our center policies and your treatment.

CONFIDENTIALITY The Center is committed to confidentiality and the privileged communication of all clients. According to Texas law, however, therapists "having cause to believe" that a child, disabled person(s), or an elderly person is being abused are required to report that information to the Texas Department of Human Services. Also, if any individual intends to take harmful, dangerous, or criminal action against another person, or against himself, it is the therapist's duty to report such action or intent.

(_____)

Client Initials

APPOINTMENTS can be made by calling (254) 722-7674. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. We ask that you give two weeks' notice if you plan to terminate treatment.

FEES Our fee is $110.00 for a 50-minute session. Your therapist may suggest consultation, psychological testing, and/or psychiatric evaluation for which you will be responsible. If you cannot afford the regular fee, an adjusted fee based on your family size and income may be available. Fee or co-pay amount is due at the time services are provided. You are responsible for full payment of your account, including the amount due if an insurance claim is denied for any reason, within thirty days after the date the claim is denied. (_____)

Client Initials

EMERGENCIES The Center does not provide "emergency service". If you have an urgent concern we try to schedule an appointment as soon as possible. If you have a critical emergency requiring immediate attention after hours, contact one of the following:
The DePaul Center (254) 776-5970, or go directly to the Providence Hospital emergency room.

CONSULTATION between partners and for the purpose of supervision, consultation, or peer review, will be protected in accordance with professional ethics and confidentiality.

CONSUMER COMPLAINTS

For all Texas licensed/certified professionals: 1 800 942-5540

Texas Department of Insurance 1 800 252-3439
P.O. Box 149104 Fax: (512) 475-1771
Austin, TX 78714-9104

U.S. Department of Human Services 1 877 696-6775
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 200201

CONSENT TO TREATMENT I voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

My signature affirms that I have read or heard the information above and that it was presented to me in clear, nontechnical language. This information is understood by me and enables me to make an informed voluntary consent to this treatment.

_____ _____

Client's Signature (or Representative) Date

_____ _____

Therapist's Signature Date