

Peace of Mind Counseling and Educational Services
Kenya Boson, LPC, M.Ed.,
7901 Cameron Rd, Building 2-#239
Austin, TX 78754
(512) 318-2503
Kenya@peaceofmindtherapy.org

Informed Consent and Practice Policies

ABOUT THIS FORM

Thank you for choosing to work with the therapists at Peace of Mind Counseling and Educational Services. Seeking therapy demonstrates your commitment to your health and well-being, and we are here to support you. This form, in addition to the Notice of Privacy Practices (HIPPA), is designed to help explain some aspects of our work together so there is a mutual understanding regarding the nature of the professional relationship. Should you have any questions or concerns, please share them with your therapist.

The therapeutic relationship is the most important factor in facilitating the lasting change that you want in your life, second only to your motivation and desire to attain these goals. You are encouraged to inform your therapist of what you want and need during therapy. You are encouraged to be open to developing a trusting relationship with your therapist and explore your thoughts, emotions, and beliefs to facilitate new insight that can lead to a more fulfilling life. Your therapist will provide you with empathy, feedback, and support in a safe, non-judgmental environment.

Your initials are required for each session below.

POLICIES AND IMPORTANT INFORMATION

____ **COUNSELING PROCESS:** The counseling process is different for each person. The issues you are addressing, your level of self-awareness, and your desire to change are all factors that will influence your counseling experience. Generally, the first few sessions are spent focusing on building the therapist/client relationship to pave the way for discussions and exploration of your issues. Your therapist cannot predict how long it will take you to reach your goals. You have a choice how much time and effort you want to contribute to your therapy. It is typical to meet once a week in the beginning of the therapeutic process, and then less frequently once progress is attained. When progress seems stable and you are comfortable with that progress your therapist will discuss terminating and ending your treatment. After termination you are welcome to contact your therapist for follow-up sessions in the future.

____ **RISKS:** While therapy may provide significant benefits such as increased insight, self-awareness, improved self-esteem, improved relationships with others, and greater independence, it may also pose risks. Therapy may elicit uncomfortable thoughts, feelings, or memories. Because some issues are painful to deal with, sometimes you might feel worse before you feel better. This experience may temporarily affect your relationship with family members or other significant relationships. This is a natural part of the growth process and usually improves as the counseling relationship continues. Your

here to support you in this process and it is important to inform your therapist of how you are being affected by your work together.

___ **OPEN CARRY/CONCEALED CARRY:** While we respect your right to carry a licensed firearm, for your safety and our own, we do not allow firearms in in office.

___ **CONFIDENTIALITY AND RECORDS:** Confidentiality laws protect client information and records. However, the following limitations and exceptions do exist:

- When there is risk of imminent danger to you or you are a risk to others.
- If therapists suspect any form of abuse, neglect, or exploitation of a child, elder, or person with disabilities
- If therapists are ordered by a court
- If you direct your therapist to release your records in writing
- If therapists are required by law to disclose information
- If therapist billing a third-party for your therapy services

___ **THERAPY WITH MINORS:** The confidentiality of the client/therapist relationship applies to minors, as well. Parents are expected to respect their child's confidentiality during the therapy process. Parents should refrain from requesting copies of their child's records and/or requesting detailed information about the therapy sessions. When appropriate and/or needed, the therapist will encourage discussions about the child's progress with the child and parent/guardian present.

___ **LATE CANCELLATION/LATE ARRIVAL/NO SHOW:** Should you need to cancel or reschedule your appointment; you are expected to provide at least 24 hours' notice. All appointments cancelled less than 24 hours ahead of the scheduled time will be assessed a \$65.00 late cancellation fee. If you cannot arrive within 15 minutes of your scheduled appointment time, your appointment will be canceled.

___ **COMMUNICATION OUTSIDE SCHEDULED APPOINTMENTS:** Due to providing services to clients, the therapist is not immediately available by telephone. When your therapist is unavailable, their telephone is answered by voicemail. The therapist at Peace of Mind Counseling and Educational Services do not accept or respond to text messages. Topics, which cannot be resolved within 10 minutes, must be addressed during a scheduled appointment. You are encouraged to contact your therapist via email for all non-life-threatening communications.

___ **EMERGENICIES:** The therapist of Peace of Mind Counseling and Educational Services do not provide emergency services. In the event of an emergency or mental health crisis, please call 911, contact your primary care physician, or go to the nearest hospital emergency room. You may also contact the National Suicide Prevention Lifeline at 1-800-273-8255.

___ **PROFESSIONAL RELATIONSHIP:** The client/therapist relationship is professional at all times. This ensures that the client receives quality care and so that we can concentrate on your concerns for your personal growth. Should you choose to engage in social media associated with Peace of Mind Counseling and Educational Services, I cannot personally engage with you on social media sites, including Facebook, Twitter or other social media venues. This protects our professional relationship and your confidentiality.

PAYMENT AND FEES

___ Your payment for therapy may be covered all or in part by your insurance or EAP benefits. IF you plan to use your insurance or EAP benefits to cover the cost of therapy, you must send that insurance/EAP paperwork to your therapist prior to your first appointment for verification. Insurance and EAP benefits do not pay the fees for late cancellations or no-shows. Those fees will be assessed to the client and due at the next appointment. Payment for services must be paid via Zelle or credit card.

Fees

- Intake (50-55 minutes) \$125.00
- Individual therapy (45-50 minutes) \$85.00
- Family therapy (45-50 minutes) \$100.00
- Marriage therapy (50 minutes) \$125.00

***Please note additional fees assessed for court proceedings and disability or short-term leave paperwork.

___ **COURT HEARINGS:** You are required to inform the therapist before establishing a relationship if you are attending therapy for court or court-related purposes/motivation. Participation in therapy does not consent to or suggest participation in any court related proceedings.

If I am subpoenaed, please note the subpoena will be directly turned over to my attorney, unless I feel prudent to disclose certain confidential information on the stand that could protect a child, elder, or handicapped person. Should you subpoena me or involve me in a court related process, please know that my retainer fee is \$1,000.00 with an additional \$200.00 for every hour involved case preparation, travel, witness time, and any wait times related to a court related proceeding. If travel is involved, you will be responsible for the cost of travel and accommodations. A bill will be rendered to you and your attorney for immediate payment.

___ **SHORT TERM LEAVE/FMLA:** You are required to inform the therapist before establishing a relationship if you are attending therapy as a requirement for short-term leave or disability requirements. The fees associated with your appointments covers the costs of therapy, only. If you request records as part of a disability or short-term leave claim, you will be required to pay a \$500.00 administrative fee, with any additional fee of \$100.00 per hour for every completion/submission of medical paperwork requested.

___ **CLIENT RIGHTS:** If for any reason you are dissatisfied with services, you have the right to your therapy terminate. If you plan to terminate therapy, please discuss your intentions with your therapist to get a referral and/or ensure the continuation of your care.

By your signature you are indicating you have read and understood this document, that any questions you had about his document have been answered to your understanding and satisfaction.

I verify the accuracy of this document, issue consent to work with Kenya Boson, LPC, and M.Ed. at Peace of Mind Counseling and Educational Services, understand my financial obligations, and acknowledge my commitment to conform to its entire specifications.

Client Name _____ Client Signature _____ Date _____

Guardian Name _____ Guardian Signature _____ Date _____

Therapist _____ Therapist Signature _____ Date _____