KJ HURT, LICENSED PROFESSIONAL COUNSELOR

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McKinney, TX 750701

(214) 802-3168
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Intake & Informed Consent for Services

Client Name:	Date:

I hereby give my consent to enter into counseling services with KJ Hurt, LPC. I understand by engaging in counseling with KJ Hurt, LPC, I agree to the following:

Counselor

I have been made aware of my counselor's qualifications & have chosen to engage in counseling with said counselor. I am aware that my counselor is licensed by the Texas State Board of Examiners of Professional Counselors (License #65565).

Nature of Counseling

I understand I must be honest & willing to share personal information about myself if counseling is to be effective. I understand that counseling may at times be difficult and/or unpleasant, depending on the nature of the issues I address. I understand that for counseling to be effective, I must be an active participant.

I understand that my relationship with my counselor is strictly professional & that my counselor will not acknowledge me in public unless spoken to by me (and my counselor will not engage in an extended conversation with me in a public place). Further, I understand my counselor will not attend any social events with me or engage in any activities outside of counseling at the counseling office.

Assessment & Evaluation

I understand my first session will be a diagnostic evaluation, in which my counselor will gather personal information for the purpose of determining issues that need to be addressed and recommendations for how to address such issues. I understand my evaluation may result in a diagnosis, if required by my insurance company or other third party payer. I understand my counselor may, at times, utilize testing instruments (i.e. Beck Depression Inventory, SASSI, etc.) in order to best determine my counseling needs.

Course of Counseling & Treatment Planning

I understand the number, frequency, & duration of my counseling sessions will be determined based upon my specific needs. I understand that I will collaborate with my counselor to develop a treatment plan & agree to work toward my treatment goals.

Family Involvement

I understand I may request family involvement in my counseling & agree to discuss this with my counselor prior to scheduling any such session(s).

Confidentiality & Records

I have been made aware of the confidentiality/privacy policies of KJ Hurt, LPC. I understand my counselor may not disclose information about my counseling without my express written consent, except in those situations identified in the Confidentiality/Privacy Notice.

Possible exceptions to confidentiality include but are not limited to the following situations: abuse or neglect of minors, elders, or disabled persons; abuse of patients in mental health facilities (§681.33 TAC, Ch.681); criminal prosecutions (§611.004 Texas Health & Safety Code, Ch. 611); child custody cases (§ 611.006 Texas Health & Safety Code, Ch. 611); situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose (§ 611.004 Texas Health & Safety Code, Ch. 611); fee disputes between the therapist and the client (§611.006 Texas Health & Safety Code, Ch. 611); or the filing of a complaint with the licensing board

(§611.006 Texas Health & Safety Code, Ch. 611)**. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this**.
I understand my counselor will maintain a record of my counseling, which will be kept for 7 years after I terminate counseling if I am an adult. My record will be kept for 7 years past my 18th birthday if I am a minor.

Termination of Services

I understand I may choose to terminate counseling at any time & I am aware that my counselor recommends a termination session prior to such termination.

PAYMENT FOR SERVICES/INSURANCE FILING

Payment is expected at the time services are rendered. I accept personal checks, cash, and credit cards. If payment becomes a hardship for you, please discuss this with me so we can arrange a suitable payment plan. **Any diagnosis made will become part of your permanent records and may have implications concerning future applications for life insurance, long-term care insurance, or future health coverage in the event of a change in health care plans**. If you have concerns regarding your diagnosis, please discuss these with me. **Within contract guidelines, the undersigned therapist will look to you for full payment of your account, and you will be responsible for payments of all charges including NSF Bank charges**.

_____ _____

Signature of Client/Legal Consenter Date

I acknowledge & agree to pay KJ Hurt, LPC, the following fees per each service provided to me by KJ Hurt, LPC.

☐ **(Initial)**

Initial Diagnostic Evaluation: $110.00
Individual Session: $95.00
Family/Couples Session: $95.00
Phone Consultation (lasting more than 10 minutes & less than 25 minutes): $30.00

In the event disclosure of your records or testimony is required by law, **payment will be expected from you, regardless of whose attorney subpoenas my involvement.** Client records will not be released without written consent, unless court-ordered to do so. Please note: a subpoena does not constitute a court order.
For legal proceedings that require my response, I bill $100 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.). The following fees also apply:

Court Testimony Preparation: $50/hour
Court Record Preparation: $70
Mileage related to Court Testimony/Subpoena: $.75/mile
Copy of Record(s): $.25/page
Counseling/Assessment Report: $95

CRISIS SITUATIONS

In the event of a crisis, every effort will be made to return your call & schedule an appointment if necessary. However, please understand that your therapist may be in sessions & unable to return your call until later in the business day. Should you need immediate assistance or experience a crisis after hours or on the weekend, please call 911 or contact the Mobile Crisis Unit at 1-866-260-8000.

DUTY TO WARN/DUTY TO PROTECT

In the event my therapist believes I (or my child if my child is the client) am at risk of harming myself or someone else, I give my permission for my therapist to contact anyone who is in a position to prevent said harm, including the person who is in danger, if applicable. Further, I give my permission for the following persons to be contacted in addition to any law enforcement or medical personnel contacted:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

SCHEDULING & CANCELLATIONS

☐ **(Initial)** I agree to attend all of my scheduled sessions & to call at least 24 hours ahead of time if I will not be able to attend my session for any reason. **I understand I will be charged the regular session fee ($95.00) for my session if I cancel less than 24 hours before my scheduled appointment or do not attend my scheduled session without calling.**

I understand my counselor will make every effort to work with my scheduling needs, as possible within my counselor's schedule & office availability.

By signing this Client Intake and Consent for Services form, I the undersigned client, acknowledge that I have both read and understand all the terms, conditions, & information contained herein. I have been provided sufficient opportunity to ask questions and seek clarification of anything contained in this agreement that is unclear to me.

_____ _____

Client(s) Signature(s)/Legal Consenter Signature Date

Permission for Professional Services for a Minor:

I have the legal authority to seek and grant permission for professional services for a minor child *& have provided the counselor with a copy of proof of such authority if applicable*,

_____, Birth date_____/_____/_____,

_____, Birth date_____/_____/_____,

_____, Birth date_____/_____/_____,

there being no legal decree disallowing my authority to assume such responsibility.

_____ _____

Client/Parent Signature Date

Client Family member signatures: All family members who are involved in this therapy need to sign below, indicating an understanding of these policies and procedures. If you have any questions, please discuss them with your therapist ***before*** you sign.

_____ _____

Client Date

_____ _____

Client Date

_____ _____

Client Date

_____ _____

Client Date