Parent Authorization, Agreement, and Consent for Treatment of Child

As a Community Counseling Clinic our responsibility and goal is the well being of our identified clients and patients. In the case of a child as the primary client, it is essential that parents and/or legal guardians are in an agreement as to decision to treat, the treatment goals, appointment times and the need to maintain client confidentiality.

As a result, it is the policy of our clinic (herein referred to as “The Clinic”) that all minors presented for treatment have the following authorization and consent on file.

Please check box most appropriate:

☐ Both Legal Parents/Guardians Consent to Treatment (Page 3)
  • Both legal parents/ guardians agree to the treatment and providing of mental health services for their child and will indicate their consent below.
  • If the biological or legally adopted parents are currently separated or going through the divorce process, both parents are still required to sign a Consent for Mental Health Treatment Form before the child can be treated.

☐ Divorce, Custody or Legal Issues (Page 4)
  • There is an official certified divorce decree or a legal custody order that indicates that only one parent is legally permitted to determine and decide on mental health treatment of the child without the consent of other parent (In this case, please provide us with a certified copy of this legal document in its entirety).

☐ Missing or Deceased Parent (Page 5)
  • The parent presenting child for treatment has no access to other parent due to the following reasons (death, in prison, missing, has left and made no contact, etc...) and therefore will acknowledge that they are the sole primary care taker of the child for mental health treatment and will bare all responsibility for such consent.

Client Initials __________                       Counselor’s Initials__________
Parent Authorization, Agreement, and Consent for Treatment of Child Continued Page 2/5

The therapeutic process is a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the providers involved to create a supportive and conducive environment for treatment.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that, which will benefit your child. This means, that you each agree as a condition of us treating your child that:

- You realize limits of confidentiality. That although we maintain full confidentiality of your reports and records with our providers and office staff, we cannot enforce confidentiality among family members, parents, siblings, and / or spouses. We do however; ask that each party respect the confidentiality of each family member.

- Our role is limited to providing treatment and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child;

- You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the other in any legal proceeding relating to the care and custody of your child;

- You understand that in the event that a provider is called into a legal or forensic relationship, or if any therapeutic material should be subpoenaed, at that point the therapeutic relationship will be considered terminated, and the provider will no longer provide counseling or related therapeutic services, but will fulfill legal obligations on a factual or forensic basis.

- If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor but we will not make any recommendations concerning the child’s custody or custody arrangements, unless otherwise ordered by a court.

Client Initials __________

Counselor’s Initials __________
Both Legal Parents/Guardians Consent to Treatment

Legal Parent 1:
I, ________________________________, ___________________________ of

(parent/legal guardian name) (relationship to child)

_________________________________, hereby authorize, with the total understanding of
the above-mentioned terms and conditions, my child(ren) to receive mental health treatment at the
UNT-Dallas Community Counseling Clinic and assume all financial responsibility for their
treatment.

I affirm that I have the authority to make health care decisions for my child(ren) and am aware
that all custodial parents and legal guardians must give consent before treatment begins.

I understand and agree that any breach of these agreements may result in the termination of any,
and all, of my (or my child(ren)’s relationship(s) with The Clinic or any of its providers,
affiliates, and/or staff members. I have been given the opportunity to ask any questions I may
have had and am voluntarily signing this agreement.

Name of Parent: ___________________________________________________

Signature: ___________________________ Date: ____/____/____

Legal Parent 2:
I, ________________________________, ___________________________ of

(parent/legal guardian name) (relationship to child)

_________________________________, hereby authorize, with the total understanding of
the above-mentioned terms and conditions, my child(ren) to receive mental health treatment at the
UNT-Dallas Community Counseling Clinic and assume all financial responsibility for their
treatment.

I affirm that I have the authority to make health care decisions for my child(ren) and am aware
that all custodial parents and legal guardians must give consent before treatment begins.

I understand and agree that any breach of these agreements may result in the termination of any,
and all, of my (or my child(ren)’s relationship(s) with The Clinic or any of its providers,
affiliates, and/or staff members. I have been given the opportunity to ask any questions I may
have had and am voluntarily signing this agreement.

Name of Parent: ___________________________________________________

Signature: ___________________________ Date: ____/____/____
Parent Authorization, Agreement, and Consent for
Treatment of Child Continued Page 4/5

**Divorce, Custody or Legal Issues**

I, _____________________________________, ___________________________ of
(parent/legal guardian name) (relationship to child)

_____________________________________, hereby acknowledge that with the total
understanding of the above-mentioned conditions and terms of agreement I authorize my
child(ren) to receive mental health treatment at the UNT-Dallas Community Counseling
Clinic and assume all financial responsibility for their treatment.

I affirm that I have the authority to make health care decisions for my child(ren) and am
aware that all custodial parents and legal guardians must give consent before treatment
begins.

I have provided the clinic with a certified or legal copy of the divorce or custody decree
that indicates that I have full authority to make any and all decisions in regards to my
child’s mental health treatment.

I further acknowledge and agree that it is ultimately my responsibility to make sure that I
am following all legal conditions set forth by my divorce decree, separation agreements,
etc. I acknowledge that the UNT-Dallas Community Counseling Clinic is requesting any
and all related documents for the benefit of my child and therefore release any liability to
UNT-Dallas Community Counseling Clinic, any of its providers, office staff, and/or
affiliates resulting from a dispute to this authorization.

I understand and agree that any breach of these agreements may result in the termination
of any, and all, of my (or my child(ren)’s relationship(s) with The Clinic or any of its
providers, affiliates, and/or staff members. I have been given the opportunity to ask any
questions I may have had and am voluntarily signing this agreement.

Name of Parent: __________________________________________________________

Signature: __________________________________ Date: ____/____/____

Missing or Deceased Parent

I, _____________________________________, ___________________________ of (parent/legal guardian name) (relationship to child)

___________________________________

, hereby acknowledge that with the total (name of child(ren))

understanding of the above-mentioned conditions and terms of agreement I authorize my child(ren) to receive mental health treatment at the UNT-Dallas Community Counseling Clinic and assume all financial responsibility for their treatment.

I affirm that I have the authority to make health care decisions for my child(ren) and am aware that all custodial parents and legal guardians must give consent before treatment begins.

I hereby swear and affirm under any applicable perjury laws that there is no legal divorce decree, custody order, or separation agreement that restricts or limits me from making any or all decisions in regards to my child’s mental health treatment. I further acknowledge that the UNT-Dallas Community Counseling Clinic has asked and attempted to collect any and all such documents from me.

I further acknowledge and agree that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreements, etc… and acknowledge that the UNT-Dallas Community Counseling Clinic is only requesting any and all related documents for the benefit of my child and therefore release any liability to UNT-Dallas Community Counseling Clinic, any of it’s providers, office staff, and/or affiliates resulting from a dispute to this authorization.

I understand and agree that any breach of these agreements may result in the termination of any and all of my (or my child(ren)’s relationship(s) with The Clinic or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

Name of Parent: ____________________________________________________________

Signature: ___________________________________ Date: ____/_____/____
Child / Adolescent Client Intake Form

Note: This form must be completed by every parent or legal guardian of a child seeking therapeutic services. If you are seeking individual counseling for an adult, couples, or family therapy at our clinic, please fill out the Individual, Couples, or Family Intake Form, and if you are bringing in your child for counseling services, please complete the Child/Adolescent Client Intake Form. Please Note, all collected information is confidential and for our clinic’s use only. The information will not be released to anyone outside of our Community Counseling Clinic without your written permission.

Child or Adolescents Information
Name: __________________________ Date of Birth: _______ Age: _______ Sex: _______

Primary Parent Information:
Name: __________________________ Date of Birth: _______ Age: _______ Sex: _______
Street Address____________________ City/State: ________________ Zip Code: _______
In an emergency, contact: __________ Phone: __________ Relationship: _______

Social / Family Information
Which best describes your family? Choose all that apply: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐ Living Together
If you are currently in a romantic relationship, for how long? ________________.
List any other individuals living in your home (other than any children listed above): ___

Medical and Mental Health History / Information
Is your child/adolescent currently being treated by a physician for any medical conditions? If so, please describe:
__________________________________________________________________________
__________________________________________________________________________
Are they currently taking prescription, over-the-counter or herbal medication?
☐ No ☐ Yes; Medication name/dose: ____________________________________________
Has your child ever seen a mental health provider? (Psychiatrist, Psychologist, Therapist, Social Worker etc.) □ No □ Yes; If yes, when and who? _____________________________
If currently, please provide their name: ________________________________
What was the focus of treatment? ________________________________
Was it helpful? □ Yes □ No

**Counseling Concerns**

What are the issues for which you are currently seeking assistance? Please be as specific as possible. (These are the issues regarding your child).
1. ________________________________ 3. ________________________________
2. ________________________________ 4. ________________________________

What have you or your child previously tried in order to resolve these issues (e.g. religious counseling, talking with family/friends)? Has anything been helpful?

____________________________________________________________________
____________________________________________________________________

What are some of your child’s coping strategies, as you have identified them?

____________________________________________________________________

**Counseling Goals**

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you or your child hope to address and achieve in counseling. Please be as specific as possible.
1. ________________________________ 3. ________________________________
2. ________________________________ 4. ________________________________

**Risk Assessment**

Is there any family history of mental illness or substance abuse? If so, please list relationship to child & diagnosis:

____________________________________________________________________

List any history of emotional, physical, and/or sexual abuse that your child may have experienced: ____________________________________________________________

Has a family member or close friend ever committed suicide? □ No □ Yes, (who)________
Do you have any reason to believe your child maybe having any thoughts of harming themselves or others?
☐ Yes ☐ No ☐ Themselves ☐ Other(s)
Why do you believe this:

____________________________________________________________________________

Are there any guns or weapons in your house (specify whose & what type) ________________________
Do you plan on using any of the information from your therapeutic sessions to address a custody, lawsuit, probation, or parole)? If so, please state which and under what circumstances:

____________________________________________________________________________

**Alcohol / Substance Use Survey (Only if they apply to your child)**

Does your child consume any drink containing alcohol?
☐ Never ☐ 1/month or less ☐ 2-4/month ☐ 2-4/week ☐ more than 4/week
How do they obtain it?

____________________________________________________________________________

Does your child use marijuana or other “street drugs”?
☐ No ☐ Yes; what type/quantity/frequency of use: _________________________________
How do they obtain it?

____________________________________________________________________________

**Referral Source**

How did you learn about our office? (Please check one and provide name as indicated):
☐ Community ☐ Physician ☐ Advertising (source) ________________________
☐ Internet (Website) ______________ ☐ Friend ____________________ ☐ Other ______________
CLIENT SERVICE AGREEMENT
NOTICE OF PRIVACY
INFORMED CONSENT

Name of Client/Patient (Child): _______________________________ Date ________

Name of Parent/Legal Guardian: _______________________________ Date ________

Name of Graduate Student Provider: ___________________________ Date ________

Name of Practicum Faculty or Clinic Director: ____________________ Date ________

INFORMATION ABOUT YOUR COUNSELOR

Each of our graduate student counselors are looking forward to getting to know you and to share with you more about their qualifications, educations, and training. The last page of this form will inform you of their background and contact information.

TREATMENT PRIVACY AND LIMITS OF CONFIDENTIALITY:

Whatever the concern that brings you to our community counseling clinic, you and your provider will spend time getting to know you and how you view yourself, how you developed through your family of origin, and your current patterns of interaction with other people. In order for us to discover, explore, and help you change, you will need to be very open and honest with your provider. Please familiarize yourself with the section below titled ‘What Therapy Is and What It Is Not’.

The things you share with your provider are protected under the confidentiality laws of the State of Texas and the United States of America. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. It is the policy of our clinic not to release any information about a client without a signed release of information. However, there are limits to confidentiality that you should know about before we begin therapy. Those exceptions include:

- Signed authorization from you to release information to a specific individual or organization
- Counselor or Clinic Director’s determination that you may harm yourself or someone else, at which point we may contact medical or law enforcement authorities.
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or a disabled individual
- Disclosure of professional misconduct of another mental health professional
- Court order or requirement by law to disclose information
- Prenatal exposure to controlled substances
- In the event of a client’s death (the spouse or parents of a deceased client may have the right to access their child’s or spouse’s records)
- If you are currently a UNT-Dallas Student, should an emergency arise, we may provide information to Dean of Student Affairs for further resource development.
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client’s records)

We will devote our sessions, usually 45-50 minutes, once a week, to helping you or your child find new ways to help yourself. Our efforts will always be legal, ethical, and relevant, and might be carried out
within our sessions as well as without, in the form of homework. It’s hard to predict how many sessions will be needed to bring about the changes you want; If you like your provider can discuss further with you how many sessions they may think it will take to reach your goals, after they become more familiar with your background.

The counseling relationship is a professional relationship rather than a social one. Please do not invite your provider to social gatherings, offer them gifts, and/or ask them to join you in any other way than in the professional context of our therapy sessions.

If your provider sees you in public, they will protect your confidentiality by not approaching you first, nor will they discuss your case with you in public. Please feel free not to acknowledge them, if you so choose. They will not feel disrespected.

Please note that it is not possible for our providers to guarantee any specific result or outcome regarding your counseling goals. That will depend on your progress and willingness to make changes in your life and behavior. We will however, work closely with you to achieve the best possible results.

For a comprehensive review of the University of North Texas Dallas Community Counseling Clinic Privacy Notice and Clinic Practices please see binder in the waiting room of our clinic or visit our website where you can download additional copies for your records. www.untdallas.edu/counseling

PAYMENT
Currently our clinic’s fees are as follows: Initial Assessment Session $20, and follow-up sessions are $15. If a financial hardship exists please mention it to our business office manager or your therapist and our office will provide you with alternative options. Please note session fees are payable at the time of service.

LEGAL PROCEEDINGS
Please note, the University of North Texas – Dallas Community Counseling Center is an educational clinic offering only therapeutic services to our community. Therefore, if any forensic services, including but not limited to child custody evaluations (social studies), court testimonies that you have filed or are a defendant, reports to be used for legal purposes, or any type of subpoena is served to any of our graduate student practitioners, please be aware that it is the policy of the clinic, that a protective order or a motion to quash will be filed on behalf of the UNT-Dallas Community Counseling Clinic.

In the event that it is ordered by a judge for any of our clinicians or supervisors to appear in court, please know we will abide by every one of our legal obligations. Often that means, simply appearing and acting as a fact-witness. In such an event, please note a legal retainer maybe required before any of our practitioners will appear in court.

SESSION RECORDING & SUPERVISION
I understand, agree, and consent that under the current set-up and management of the University of North Texas Dallas Community Counseling Clinic, I will be provided counseling services by current Practicum or Internship students enrolled in the Counseling Program at UNTD, or approved by the Community Counseling Clinic Director. I further understand that each provider in training will be under the supervision of either a faculty member and/or the Community Counseling Clinic Director. I agree that in order for this supervision to be complete and valuable that my sessions will be recorded so that the licensed supervisor can review the video and ensure I am being provided the best therapeutic care. I have been made aware that only those with the need to see the video will view them, and have been informed that any and all individuals viewing such videos will have been trained with Protected Health Information confidentiality training. I further understand that all my recording will be destroyed and deleted after the termination of my file at the UNTD Community Counseling Clinic.
CLIENT RIGHTS
It is your right at any time to inquire about the process and procedures being used during our counseling relationship. You have the right to refuse or negotiate modifications of any of my suggestions.

We assure you that our services are rendered in a professional manner consistent with ethical standards of the American Counseling Association and the Texas State Board of Examiners of Professional Counselors. If for any reason you believe our services are unethical, please let our office manager or clinic director know. If we are unable to resolve these concerns, you may report your complaints to the Texas State Board of Examiners of Professional Counselors in Austin at 1-800-942-5540.

Once you begin treatment with us, there is no obligation to continue. You have the right to discontinue at anytime, though we may ask that you participate in a termination session.

You may or may not have been to a therapist before. If this is your first experience with therapy, you may feel a bit nervous or apprehensive. That's normal!

Therapy is a process that allows you the freedom and privacy to discuss issues that are often painful or difficult to discuss with family and/or friends.

The following are a few suggestions to help make your counseling experience most effective:

1. Before your scheduled appointment, write down questions, topics, or issues you would like to focus on in your session.
2. Communicate your expectations to our providers so that we are working together toward your goals.
3. Provide ongoing feedback to your provider so that they know how you are doing (example, "I want to focus on my anger more" or "I like doing relaxation exercises").
4. If you feel a need to increase or decrease the frequency of your sessions, or to end counseling, feel free to communicate that to counselor/therapist.
5. If you feel a need to bring a partner, relative, or friend in with you for your session in order to work on interpersonal issues, feel free to do so. Please discuss it with your provider prior to their arrival.
6. If you have another professional involved in your care (i.e. physician, chiropractor, attorney, etc.), we would be happy to coordinate with him/her if you wish. It is not advisable to have more than one mental health counselor involved in your treatment at one time.
7. Try to make a commitment to yourself to remain in therapy and attend regular sessions for as long as you feel necessary. If you wait until you have a crisis, it will be more difficult to build long-lasting coping skills.
8. If for any reason you would like to see a different therapist, please feel free to tell our office. We can provide you with either another provider or recommend to you other therapists in the area.

KNOWN BENEFITS OF COUNSELING AND PSYCHOTHERAPY

Research has shown that most of the common approaches to therapy are about equally successful. In general, the typical psychotherapy clients are better off after therapy than they were before it, and they are better off after therapy than 80% of untreated persons. This means, in other words, that you may have about a 20% chance of feeling better if you simply wait a few months or couple of years. Of course, statistics are usually more complicated than that. You should know that there is about a 5% chance that therapy may make you feel worse. A study by Consumer Reports said that typical clients in typical kinds of therapy for long enough periods of time actually find significant improvement. And it shows that generally speaking, the longer one stays in therapy the more the improvement one experiences.

Therapy is very helpful when the client is depressed, anxious, unhappy, a survivor of trauma of many kinds, or suffering from a life-problem which requires careful thinking and involves lots of emotional energy. People who can talk and listen reasonably well, who are reasonably comfortable being alone with
another person, and who are willing to pay attention to their own feelings, thoughts, and motivations probably will do well in psychotherapy. Often, psychotherapy can be enhanced by medications designed to decrease depression or anxiety symptoms. If so your therapist will discuss this with you.

Psychotherapy has been shown to help people who are passive to become more assertive, and to feel better because more of their needs are met. It has been shown to help people with high anxiety feel more calm and to become more able to calm themselves down. People who are depressed often are helped a great deal, especially to identify and change the ideas and beliefs which may contribute to their depression. Most successful therapy clients change behaviors and lifestyles which keep them unhappy or stuck. Of course, none of these people are helped if they do not pay attention to their actual feelings and thoughts and talk them over candidly with the therapist. Nor are they helped if they refuse to change anything in their attitudes or their behaviors.

People who are helped by psychotherapy typically report that they feel less unhappy, that their physical sense of well-being is improved (for example, their appetites improve, their sleep habits improve, they have more satisfying sexual lives, and often their general health improves). People with chronic pain problems may not have less pain, but they often report feeling more able to live productively despite the pain and to not be so distracted by it. Sometimes, especially when they use additional tools such as hypnosis, they find that even their level of pain might decrease at least some.

COMMON RISKS ASSOCIATED WITH COUNSELING AND PSYCHOTHERAPY

There are risks to psychotherapy. The first and most important one is that people often feel worse as the therapy progresses. Sometimes this is natural; after all, talking about problems breaks down our usual avoidance of them, and the pain associated with them can then be felt more vividly. In some cases, however, the worsening is due to mistakes on the therapist's part, such as moving into painful material before the client is actually ready. In this case, recognizing the problem and "slowing down" usually takes care of the worsening. If the therapist does not "slow things down," however, the worsening can sometimes be serious.

It is very important to let your therapist know how you are experiencing the therapy. If it seems to be making you feel worse, maybe it is. Telling your therapist allows exploration of what is happening, so you can decide whether the worsening is to be expected or whether the therapy is moving too fast.

Some clients develop strong feelings about their therapists. This, especially in longer therapies, is normal, even if it is sometimes uncomfortable. Any feelings are possible, and the rule for them all is to talk them over with the therapist. You should never feel shamed or humiliated by your therapist for anything that you discuss in therapy. If you do, inform your therapist; perhaps the feeling comes from you, but therapists must take great care not to intentionally shame or humiliate their clients. If your therapist continues to humiliate you intentionally, find a different therapist.

Therapy can complicate your life. After all, you may discover that you have feelings about people which you never realized you had. You may want or need things you had overlooked, and may not have access to them yet. You may have had experiences in the past which must be reconciled, and sometimes that is cumbersome.

Of course, the fee you must pay for therapy can pose a risk to you financially. You should carefully consider the fee and your ability to pay it over the entire estimated course of therapy before you begin, lest you find halfway through that you can neither stop nor pay the fee.

When clients cannot stay in conscious connection with their feelings, thoughts, or behavior, psychotherapy is not as helpful. The risk is that it might make them feel worse, or cause anxiety. In general, if the requirements of psychotherapy (such as talking, listening, being able to feel reasonably safe with the therapist, being able to learn from discussion with someone, and so on) cannot be met, psychotherapy poses a risk of making the client at least waste time and money, and at worst of becoming worse.

Psychotherapy can also help with marriage and relationship problems. However, you should know that some research suggests that when one spouse or partner meets alone with a therapist to discuss problems
involving the other partner, although it may help the person in therapy, the chances of separation may go up.

The therapist can also offer suggestions and advice when they are appropriate, but you must know that research shows that a therapist's advice about life problems is often no more helpful than that of other persons. Helping you find your own solutions is far more important a job of the therapist than telling you what the therapist’s solutions is.

RISKS ASSOCIATED WITH MEMORIES

Since therapy depends on talking about your experiences, even in the past, your memory is involved, and memory is not always completely dependable. Your therapist can help you learn more about how memory works, if you are interested in that. But there are two main risks in therapy regarding memories: First is to take memories as being too dependable (as if all memories were always accurate); and second is to take memories as being too fallible (as if no memories from the distant past are reliable). In fact, the truth is in between.

If you assume your memories are always accurate, therapy can be risky. For instance, if you perhaps remember an abuse by someone in your past, and without any proof that it actually happened as you think it did, you accuse them, this may needlessly harm another human being, which in our opinion is never acceptable. A further risk is that the accused may retaliate and sue you or your therapist. This happens with increasing frequency. This of course will jeopardize your therapy, and may require that it be terminated prematurely.

The other large risk associated with memory, especially memory of abuse, is to assume that it is never reliable, especially if the memory is unclear, vague, fragmented, or seemingly absurd. There is strong evidence that extremely traumatic memory is not stored like normal memories, and may be recalled in fragments, images, and sensations without logical stories attached. So just because a memory seems hard to put together does not automatically mean it is false, any more than it is automatically true. The risk is that we can miss the truth either way.

RISKS ASSOCIATED WITH DIAGNOSIS

Every good therapist makes some kind of "diagnosis" of your problems. This means that there is a "summing up" which describes in shorthand what is wrong and what is going to be the target of therapy. Even saying, "You are unhappy because you lost your job" is a form of diagnosis. Psychiatric diagnoses are condensed phrases which tell what your symptoms are and what the therapist assumes to be the cause(s) of your difficulties. The risk of making a wrong diagnosis is that the wrong treatment will follow.

The benefit of making any diagnosis is that therapy has a much better chance to succeed when it has a reasonable focus, which a good diagnosis can provide.

To avoid the risks of misdiagnosis, be sure that the therapist knows the whole story. Tell the truth as well as you can, and if something occurs to you, tell the therapist. Therapists are supposed to take complete histories, and to consider carefully what medical problems might be causing your symptoms. Sometimes they will ask you to see a physician to make sure some medical problem is not causing your symptoms. All this is to help them make the proper diagnosis. If you have any concern that the therapist does not sufficiently know or understand your situation, don't hesitate to stop the process and say so. In this way, you can help avoid a misdiagnosis and the wrong decisions about treatment.

We strongly recommend that you not discuss your diagnosis with anyone except your therapist and your most trusted associates. Employers or people who do not have your best interests at heart are not appropriate persons with whom to share your diagnosis. The risk is that they may take as a "permanent truth" something which is in reality only a therapeutic shorthand description of something you hope to change.

Another risk associated with diagnosis is that some persons are upset by it. Some people do not understand it and some people even feel ashamed of their diagnoses. Please ask anything and everything you need to in
order to understand and accept your diagnosis. If you feel ashamed or belittled by it, talk this over until the feelings become manageable. No diagnosis needs to be a permanent, life-long prison sentence. One of the early hurdles in therapy is arriving at an accurate and helpful diagnosis and then helping the client become educated and reasonably comfortable about it.

OTHER RISKS ASSOCIATED WITH THERAPY

Unexpressed feelings about any of the "rules" of therapy can derail your progress. If you resent paying the fee or wish for longer sessions, please tell your therapist of these feelings. Even if nothing can be done to change the situation, the feelings can change if they are discussed.

Therapists are required by ethics codes and by law never to have an outside relationship with their clients, including any form of sexual relationship. Even semi-sexual touching is forbidden. The privacy, intimacy, and personal nature of therapy sometimes can make feelings quite strong between a therapist and a client. If this happens, tell your therapist immediately. If your therapist does not respond in a way you can be comfortable with, you can stop therapy and notify the proper authorities.

Sometimes problems that were not apparent to you at the start emerge during the therapy. When this happens, it is discussed between therapist and client and a new treatment plan is developed to solve them, or they are not addressed. Sometimes, present problems which seem minor become larger and must be addressed. Again, a new treatment plan will be developed if that should happen, and nothing will be done without your full consent.

NO ABSOLUTE GURANTEES

Based on experimental research, there are no guarantees that therapy will help you get better. But based on over a century of consistent clinical experience, we know that therapy helps many people achieve meaningful improvement in their lives. We have found five variables to be predictive of success: (1) When the therapist is comfortable with and believes in what he or she is doing; (2) When therapist and client share a collaborative relationship in which they respect each other and feel a positive bond; (3) When the client is allowed to talk freely and to feel emotions fully; (4) When the therapist is well-trained, has experience, and competently uses skills known to be helpful; (5) When there is enough empathy between the two that the client feels safe and supported taking risks and accepting the therapist's challenges or confrontations.

Some people claim that there is little "scientific evidence" that therapy is beneficial. This is not actually true. Furthermore, "scientific research" has serious limitations when studying real-world situations like therapy. Many things known to be important and useful in life are not "proven" scientifically. Aspirin is a simple yet useful example. Though we cannot guarantee that therapy will help you, and would remind you that there is a slight chance (5% or less) that it might make you worse, we believe that it is quite likely to help you at least to overcome your immediate problems or symptoms and to feel well enough to live more productively. We will gladly share the research studies which address these matters. At times therapy will be difficult and uncomfortable. We cannot say how long it will last, but we will share our best estimate with you, once we know what the problems are. If anything changes as we go along, we will talk it over with you and will never do anything without your consent.

I understand that I must be dedicated to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision prior to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon.
CHILD COUNSELING/PLAY THERAPY LOGISTICS:

For play therapy, sometimes it may be necessary to end the session early depending upon the following circumstances: the condition or cleanliness of the playroom, the child’s ability to leave when the session is over, a situation where play therapy could no longer continue (e.g., child gets sick, child breaks several toys, child chooses to leave and not return, etc.), and the need for a parent consultation.

**Because the session may need to end early at times, please be sure to remain in the waiting room for most of the session.** If you leave the waiting area please advise the administrator that you are leaving and provide a contact number.

Children in the playroom are not asked to clean the room following the session. The reason for this is as follows: If play is a child’s language and toys are the child’s words; having a child clean up the play room following the session would be analogous to asking the child to clean up his/her emotional world. It would be similar to having an adult take back everything he/she said at the end of the counseling session. This is a unique stipulation to play therapy—please know I am not advocating this action for other circumstances—only play therapy.

When the child greets you in the waiting room following the counseling session, it is **best not to ask several questions**, such as “Did you have fun?”- While playing is a natural, pleasurable activity for the child, children in play therapy are involved in playing out problems and emotional struggle and, therefore, at times “playing” may not be so enjoyable. Furthermore, when asked what the child did in play therapy, the child will typically respond, “I played.” This would be similar to asking an adult in counseling what he or she did in the session—“We talked.”

**Before your child attends play therapy,**

1. Please take them to the bathroom. Play therapy can often be very emotionally freeing, causing the child sometimes to have to use the bathroom during therapy. It is helpful if the child goes to the restroom before the session begins.

2. Also, if your child is coming from school and is hungry, please give them a snack before therapy starts. Only in rare circumstances will food be provided for a child in play therapy. In such a situation, this will be discussed with the caregiver and added to the treatment plan.

3. Please know that the playroom has a variety of media that can be messy (e.g., easel paints, water-color paints, Play-Doh, clay, water, sand, etc.). Please dress your child in clothes that can tolerate mess or possible stains should the child spill paint on themselves.

4. Also, if your child is allergic to any substance that falls into this realm, it is your responsibility to let the play therapist know so that appropriate modifications can be made for your child.

The play therapist will **briefly** meet with you to give feedback on your child **every other session.** While the feedback will discuss overall play themes for your child, discussion on several specific play behaviors will not be discussed to protect the child’s confidentiality. However, most certainly at times, it will be necessary to discuss specific play behaviors and what this may mean for your child.
MISSED APPOINTMENT AND SAME-DAY CANCELLATION POLICY

I understand that unless a verifiable emergency exists, I must cancel or re-schedule my appointment **24 hours in advance. Same-day cancellations will incur a $15 fee** applied to my account and my failure to attend a scheduled appointment without cancellation (**a “no-show”) will incur a full session fee** to my account. I further understand that the voicemail system of the UNT-Dallas Community Counseling Clinic records the day and time of all messages left. **If I cancel appointments on a consistent basis or miss appointments three times in a row without reasonable cause, The UNT-Dallas Clinic reserves the right to refer me elsewhere for services.** I understand that this policy is not meant to be punitive, but instead is to request consideration for the professionals who are providing me and the community a valuable service. My appointment time is reserved for me at the exclusion of others who may be waiting to see the therapist.

Furthermore, I understand that due to the nature of the training clinic, once I set-up an appointment at the beginning of a academic semester, my appointment will be deemed an “standing” appointment, meaning it will repeat the same time on the following week, unless instructed by the clinic administrative assistant, my graduate provider, or the clinic director. I understand that I have the right to cancel an appointment 24-hour in advance of a scheduled session and will not incur a financial penalty for that session. However, in consideration for the graduate students and their need to complete their training hours, I understand and agree that if life circumstances cause me to need to cancel 2 consecutive appointments with a 24-hour advance notice, that I will lose my “standing” appointment spot and once I’m ready to resume my appointments will need to be worked back in to the schedule either with the same counselor or another provider.

My signature below affirms that I am satisfied with the explanation and conversations I have had with my counselor or UNT-Dallas Community Counseling Center representative. All my questions have been fully answered, and I understand that if more questions arise, I have the right to have them answered as well. Further, I acknowledge that I have been given information regarding informed consent for counseling, psychotherapy, and other mental health services. That I am signing this (Client Service Agreement, Informed Consent, and Office Policy document) and that the disclosed information has been made available to me in a simple non-technical language. Additionally, I have been made aware of the nature of the therapy including the risks and benefits.

SIGNATURE PAGE Follows
This disclosure was understood by me and I voluntary agreed to the treatment. I also understand that I may cancel this consent at any time without any penalty. I understand that this informed consent form will become a part of my records.

_______________________     _________________________     ___/___/___
Client’s Legal Representative’s Name    Signature    Date

CONFIRMATION OF RECEIPT AND ACCESS TO PRIVACY NOTICE, INFORMED CONSENT, AND PROFESSIONAL DISCLOSURE STATEMENT

My signature below affirms that 1. I have either asked and received, or made a copy of the Notice of Privacy, Informed Consent, and my Counselor’s Professional Disclosure Statement. 2. I further acknowledge that I have either downloaded, found, or asked and was given a comprehensive copy of the Privacy Notice Practices of the UNT-Dallas Community Counseling Clinic. 3. I voluntarily and without coercion agree to participate in the planning of my care 4. Agree to release from Liability and Hold Harmless the UNT-Dallas Community Counseling Clinic, The University of North Texas Dallas or the State of Texas from any personal liability or negative outcome that might arise or result from any and all of my engagements (psychological, emotional, physical, legal, or financial) with the UNT Dallas Community Counseling Clinic.

_______________________     _________________________     ___/___/___
Client’s Legal Representative’s Name    Signature    Date

I have discussed this memo with the client, named above, I have shared with them my professional disclosure statement, both in writing and verbally, and I have no reason to believe that the client was unable to fully understand the nature of our relationship, my training preparations, or other material we discussed.

Graduate Student’s Name and Signature: ____________________________ Date ___/___/___

Practicum Faculty Name and Signature: ____________________________ Date ___/___/___