Jennifer L. Thomas, M.Ed.
Licensed Professional Counselor #77155
320 S. Polk, Suite 301
Amarillo, TX 79101

Phone: (806) 310-2634 **Fax: (806) 223-4878**

IMPORTANT INFORMATION AND CLIENT CONSENT

GENERAL INFORMATION

My name is Jennifer L. Thomas. I have a Master's Degree in Clinical Mental Health Counseling and am a Licensed Professional Counselor, #77155, in the State of Texas which allows me to provide individual, couple, family and group therapy.

I work with children, adults, couples, and families from across the lifespan dealing with various issues in their lives. Although I am capable of handling a variety of problems, there may be situations in which I will recommend you to another specialized therapist so you will be better served. Please note that I am not a Psychiatrist, (who is a medically trained doctor), so I am unable to prescribe medication. Also, I am not a Licensed Psychologist and I am unable to administer certain diagnostic tests. I do not provide evaluations for court proceedings. If psychological tests are needed for court proceedings or diagnosis, those will need to be referred to a psychologist.

My approach is an empathetic talk therapy that incorporates multiple therapeutic interventions such as Family Systems, Marital (if married), Group, Child/Adolescent/Play Therapy, Art/Music Therapy, Cognitive/Behavioral, Solution Focused, Emotion Focused, and Restoration Therapy Modalities. My foundation is Christian based and I will seek to incorporate the faith of the clients into therapeutic interventions. However, I will strive to respect client boundaries and personal spiritual beliefs and will in no way impose my beliefs on clients. My goal will be to establish a safe environment to journey with a client to achieve emotional healing.

APPOINTMENTS

Your first initial visit will be an assessment session in which you and I will determine your concerns, and if we both decide that I can provide your therapeutic needs, then we will work on treatment objectives together. Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. Children's sessions will be adjusted according to age and ability to focus. Please note all children under the age of 12 must have adult supervision and adults must remain on premises during sessions. Group sessions are approximately 90 minutes long. **If you must cancel or reschedule your appointment, please call 806-310-2634 at least 24 hours in advance. Appointments that are not canceled at least 24 hours in advance will be charged to your account.**

Due to the confidentiality policy, excluding minors, we are unable to schedule, confirm, adjust or cancel an appointment from anyone other than the client being seen unless a signed release is on file. If you and your spouse/partner are being seen together for the indicated session, it is acceptable for one party to schedule, confirm, adjust, or cancel an appointment. However, we will not notify the spouse/partner of the appointment change. In the event of a family or medical emergency a note will be made on the account without disclosing to a third party or family member unless a release is on file.

Services are by appointment only by calling 806-310-2634. Please leave a message and every effort will be made to return any call left during normal business hours within 24 hours. Messages left after 3:00 Monday through Wednesday or after 12:00 on Thursday will be returned the next business day. I am out of the office on Fridays, weekends and most holidays. Those messages will be returned the next week during normal office hours.

PAYMENT

The fee for an initial assessment with me as a Licensed Professional Counselor session is $**175.00.** There may be other fees assessed for separate profiles or educational materials. The fee for a regular 50-minute session thereafter

is $**150.00**. The fee for a 30-minute session is **$75.00**. These fees are subject to change upon prior notice to you. A 24-hour advance notice for cancellations (non-emergency) is required to avoid a session fee.

I am considered an out of network provider with most insurance companies. If you wish to file with your insurance company for reimbursement of fees, I can provide you with the information required.

Full payment of fees is expected at the beginning of each appointment. Subsequent sessions will then be scheduled at the conclusion of that session if determined necessary. By signing this agreement you understand that you are fully responsible for all fees. I accept cash, check, or credit card.

LITIGATION

In unusual cases you may become involved in litigation that may require my participation. My focus in providing counseling is on treatment and healing. It is NOT my intention to become involved in cases that require evaluation or testimony. When subpoenaed, I may obtain my own legal counsel. If I am required to appear in court or conference via telephone, the client or guardian associated with the subpoena/court request will be required to pay for the preparation time at a rate of **$200.00** per hour. In addition, my fee for participation is **$800.00** for a half day (4 hours) and/or **$1600.00** for a full day. A minimum of **$1000.00** is to be paid 48 hours in advance. Because I must cancel other appointments for this appearance and preparation, this payment will not be refunded for any reason. Additional time required will be billed thereafter.

RISKS/BENEFITS

Therapy can be beneficial to those that seek assistance, but as with any treatment, there are inherent risks. Therapy is designed to assist clients in resolving issues and to deal with painful life problems. I will make every effort to make therapy successful in this manner. However you should know that there is no guarantee that you will solve your problems or that all of your issues will be resolved. During counseling we will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness or even more distress. If distress surfaces, please let me know.

Participation in therapy means that you accept these risks and are willing to deal with the potential problems that could arise. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course, but it is my desire, however, to work with you to attain your personal goals for counseling.

It is agreed that the client shall make a good-faith effort at personal growth and engage in the therapeutic process as an important priority at this time in his/her life. Suspension, termination, or referral shall be discussed for lack of commitment or for any unresolved conflict or impasse between counselor and client as soon as possible.

MINORS

Minors must have parental consent for counseling with the exception that the client is:

- 16 years of age or older and resides apart from the parents/guardians and manages his/her own financial affairs
- Thinking about suicide
- Concerned about alcohol or drug addiction/dependency
- Being sexually, physically, or emotionally abused.

Consenting parents have the right to examine the treatment records of children under the age of 18.
In order that minors may have the trust of a protected environment, it is your therapist's practice to ask the parents to forego that right (progress with the parent/guardian may be discussed) with the exception of extreme circumstances (see confidentiality).

At the termination of treatment, and upon request, your therapist can provide the parent(s)/guardian(s) with a summary of treatment. It is important to note that in the state of Texas children under 17 may not have consensual sex (by law it is considered indecency with a child and therefore child abuse) and the state of Texas requires a therapist to breach confidentiality and report such activity to Child Protective Services (CPS). If your therapist is required to make such a report to CPS about your child, you will be informed as well.

CONFIDENTIALITY OF ALL ELECTRONIC COMMUNICATIONS
This includes but is not limited to the following: Email, Skype (or any other face time service), chat, mobile devices, cell phones or fax. Please know that our office will maintain your confidentiality to the best of our ability; however, we cannot guarantee this with any electronic communication. Please do not send e-mails or texts related to your treatment, and limit any electronic communication to scheduling only. **Any therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during your next therapy session**. Any electronic communication by you will be retained in the logs of your service records. While it is unlikely that someone will be looking at these logs, they are in theory, available to be read by the system administrator(s) of the service provider. You should know that any e-mails or texts received from you and any responses sent will become part of your therapy record.

In the event you are contacted or place a call to our staff, please be aware that unless we are both on landline phones, the conversation is not considered confidential and it is possible that your PHI/ePHI could be exposed. Likewise, text messages are not confidential and it is not advised or appropriate to converse about personal issues via text. Face to face sessions are for this purpose. I will make every effort to keep all information confidential. Likewise, it is important that you carefully determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors, and friends. Please only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured.

DUAL RELATIONSHIPS/SOCIAL NETWORKING
Not all dual relationships are unethical or avoidable. Dual relationship situations might impair your therapist's objectivity, clinical judgment, or therapeutic effectiveness, thus will not be encouraged. If our paths should cross in public, I will not acknowledge you unless you initiate contact. It is preferred that you decide whether or not to disclose your acquaintance (therapist) to others.

Please be aware that our social networking sites are utilized as a "blog" and not intended to replace personal therapy sessions. In regards to your therapist's personal social networking sites, your therapist may choose not to accept your invitation in the interest of protecting your privacy.

RELEASE OF INFORMATION
If information needs to be released it will only be done according to state law and with a written consent (separate form) from the client indicating an informed consent of such release. In the case of marital therapy, the client is the couple, not individuals; therefore, all records can only be released when both parties consent in writing or if mandated by the court.

INCAPACITY OR DEATH
In the event of the incapacitation or death of myself, it will be necessary to assign your case to another therapist and for that therapist to have possession of your treatment records. By your signature on this form, you are consenting to another LPC/ LPC-Supervisor, LMFT/LMFT Supervisor, which are personally chosen colleagues preferred by myself, to take possession of your records OR to deliver them to another LPC/LPC-Supervisor, LMFT/LMFT-Supervisor of your choosing.

EMERGENCY SITUATIONS
It is my desire to provide the highest level of care to clients both inside and outside of sessions. For scheduling and non-emergency situations, please contact me at 806.310.2634. In the event you encounter a personal emergency, which will require prompt attention, I will make every effort to accommodate an appointment. If your emergency arises after hours or on the weekend, clients are encouraged to contact a family member, call the Crisis Line at 806-359-6699, call 911 or go directly to the nearest emergency department.

MODIFICATION AND CONFLICT RESOLUTION
It is agreed that any disputes or modification of agreement shall be negotiated directly between the therapist and client(s). If these negotiations are not satisfactory, then the therapist's client(s) agree to mediate any differences with a mutual acceptable third-party mediator, consisting first of another therapist of the practice. If these negotiations are unsatisfactory, the parties shall move to arbitration and then binding arbitration, choosing an arbitrator mutually

agreeable by both. Litigation shall be considered only if and after all of these methods of resolution are given a good faith effort and are unsatisfactory.

CONFIDENTIALITY

Discussions between a therapist and a client are generally confidential and protected by law. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations:

- Child abuse
- Abuse of the elderly or disabled
- Abuse of patients in mental health facilities
- Sexual exploitation
- AIDS/HIV infection and possible transmission
- Criminal prosecutions
- Child custody cases
- Suits in which the mental health of a party is in issue
- Situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose
- Fee disputes between the therapist and the client
- Negligence suit brought by the client against the therapist
- Filing of a complaint with the licensing or certifying board

If you have any questions regarding confidentiality, you should bring them to my attention so that we can discuss this matter further. I hold confidentiality between clients in the highest regard and will make every effort to protect information shared in our session together. By signing this Information and Consent Form, you are giving consent to Jennifer L. Thomas, LPC to share confidential information with all persons mandated by law, with the agency that referred you and are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result. **For further information, review the Notice of Privacy Practices furnished to you by your therapist, at your request, with this client information and consent document.**

DUTY TO WARN/DUTY TO PROTECT

If my therapist believes that I (or my child, if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Person to be contacted and phone number: _____

Relationship:_____

IN CASES OF SEPARATION OR DIVORCE: You agree to provide me with legal documentation regarding conservatorship and your legal rights to consent to treatment for your child. If parents share joint managing conservatorship, both must sign consent to treatment. I will provide treatment that will help facilitate your child's adjustment to the separation or divorce but I do not provide forensic interviews, custody or visitation evaluations, or release of records. I do not serve as an expert witness or provide testimonial services in custody battles. By signing this form, you agree not to subpoena me to court for testimony or for disclosure of treatment records.

CONSENT TO TREATMENT (Please Initial and Sign Below):

_____ I have received a copy of the Informed Consent and Practice Policies from the offices of Jennifer L. Thomas, M.Ed., LPC

_____I consent to the evaluation and treatment of mental health services, including consultation, evaluation/ assessment, treatment planning, and psychotherapy. Although my chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop treatment.

_____ I have read the notice of privacy practices which explains in more detail what my rights are and how my PHI information can be used and shared. I am aware that if my therapist suspects potential child or elder abuse, or has been given reason to believe a client may harm themselves or someone else, the therapist may be legally obligated to breach confidentiality to notify appropriate authorities or individuals.

_____ I understand the risks and limitations to confidentiality with the use of electronic correspondence.

_____I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought and authorize the release of necessary medical information for insurance reimbursement purposes.

_____I have the right to file a complaint if my services fail to conform to the professional code of ethics or licensing laws. To file a complaint with the Texas State Board of Examiners of Professional Counselors, I may contact them at:

Texas Behavioral Health Executive Council
George H.W. Bush State Office Building
1801 Congress Ave., Ste. 7.300
Austin, Texas 78701
Main Line (512) 305-7700
Investigations/Complaints 24-hour, toll-free system (800) 821-3205
www.bhec.texas.gov

By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I agree to participate in therapy with Jennifer L. Thomas, M.Ed., LPC. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if child is the client), and I understand that I may stop such treatment or services at any time.

_____ _____
Signature of Client or Client's Consenting Adult (if under 18) Date

_____ _____
Signature of Client or Client's Consenting Adult (if under 18) Date

_____ _____
Signature of Therapist Date

HIPPA/HITECH ACKNOWLEDGEMENT OF RECEIPT

Jennifer L. Thomas, M.Ed.
Licensed Professional Counselor #77155
320 S. Polk, Suite 301
Amarillo, TX 79101

Phone: (806) 310-2634 **Fax: (806) 223-4878**

Printed Client's Name: _____

Client's Birth Date: ____/____/____

The Office of Jennifer L. Thomas, M.Ed. LPC, is required by law to maintain the privacy of and provide individuals with the "Notice of Privacy Practices" with respect to your PHI/ePHI (Protected Health Information/ Electronic Protected Health Information). This notice is located with our informed consent. You may also receive a separate paper copy at no charge upon your request. If you have any objections to this notice, please speak with Jennifer L. Thomas, LPC.

I hereby acknowledge that I received and reviewed the HIPAA/HITECH Notice of Privacy Practices.

_____ _____
Signature of Client or Client's Consenting Adult (if under 18) Date

_____ _____
Signature of Client or Client's Consenting Adult (if under 18) Date

_____ _____
Signature of Therapist Date

INTAKE FORM

Jennifer L. Thomas, M.Ed.
Licensed Professional Counselor #77155
320 S. Polk, Suite 301
Amarillo, TX 79101

Phone: (806) 310-2634 **Fax: (806) 223-4221**

PERSONAL INFORMATION

CLIENT(S) NAME: _____

LEGAL GUARDIAN (if minor client): _____

ADDRESS: _____
Street, City, State, Zip

PRIMARY PHONE: (_____) _____ CELL PHONE (_____) _____
Permission to leave message? YES NO

PRIMARY EMAIL: _____
Permission to Email and/or Text? YES NO

Birthdate: _____
Age: _____
Race/Ethnicity: _____
Birth State: _____
Relationship Status:_____

Last grade attended/degree completed: _____
Employer: _____
Length of Employment: _____
Occupation: _____
Gross income: _____

Emergency Contact: _____
Phone: _____
Address: _____
Relationship to the client: _____

PLEASE CIRCLE BELOW

Rate your physical health: Excellent Good Average Fair Poor

Recently: Lost Wt. / Gained Wt. How much? _____

Average hours of sleep per night _____ Trouble with: falling asleep___ staying asleep____

Do you drink: coffee (____cups per day) tea (___cups per day) Cola (_____oz per day)
alcohol (_____type _____quantity per day/week)

Do you smoke/use: cigarettes and/or marijuana? Yes / No If yes, describe:_____

Hours per day on computer, phone, or gaming system, for games, social media, etc: _____
Has anyone ever suggested there might be a problem with alcohol, computer, social media, shopping, or other excessive behavior? _____.

Describe use of non-prescription drugs including aspirin _____
_____

Currently taking prescription drugs? (List type and reason for use)_____
_____

Family physician _____ What type of regular exercise?_____

Have you ever had a severe emotional upset?_____ If yes, describe:_____
_____

Did this upset require medication or hospitalization? _____ If yes, describe:_____
_____

Have you ever had thoughts about suicide? _____ If yes, please explain:_____
_____

Have you ever attempted suicide? _____ If yes, how many times? _____

Is spirituality important to you? ____not at all ___important _____very important
If important, name of church/temple you attend: _____

FAMILY HISTORY

Raised by _____blood parents? _____other (explain)_____
Parents divorced? _____ If yes, how old were **you** at the time? _____
If parents are deceased, how old were **you** when they died? _____Father _____Mother
Number of siblings _____ Are you the ____oldest ____middle_____youngest? (check one)

Marriage Information…If NEVER married, omit this section otherwise check all that apply:

_____presently married
_____remarried (____times/ dates:_____)
_____separated (_____months/years)
_____divorced (_____months/years)
_____widowed (_____months/years)

Spouse's name_____
Length of courtship:_____
Date of marriage:_____
Age when married-yours_____spouse_____
Spouse previously married?_____

How well do you and your spouse get along at the present time? Check One
____Very well ____Well ____OK ____Not very well ____Poor

List all other persons living with you in your home at this time:

Name	Age	Sex	Relationship
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Do you or spouse have children who live elsewhere? _____if yes, with whom_____
_____

State in a short phrase or sentence current reasons for seeking therapy (presenting issue):
_____
_____

When did the present problem start?_____

_____

Circle the severity of the concern in regards to the presenting issue:

MILDLY UPSETTING	MODERATELY SEVERE	VERY SEVERE	EXTREMELY SEVERE	COMPLETELY INCAPACITATING

Therapy/counseling before? YES NO If yes, how many sessions? _____
Currently seeing therapist/counselor? YES NO

Name of counselor, and addresses and dates of any previous counseling:_____

_____

How satisfactory was the therapy/counseling received (1 being not satisfied to 5 being satisfied)?

1	2	3	4	5

What else, if anything, has been attempted to correct the problem?_____

_____

Were you referred to us? _____ (If yes, by whom) _____
May we have permission to thank them for this referral? YES NO

In your estimation, circle how interested in counseling you are now:

SOMEWHAT	MODERATELY	VERY INTERESTED

Any other information important in preparation for counseling:_____

_____

What is the anticipated outcome of therapy? What is/are your goal(s)?_____

_____

By signing below you acknowledge you have read this notice and agree to the terms.

_____ _____

Signature of Client or Client's Consenting Adult Date

_____

Relationship if Consenting Adult

_____ _____

Signature of Therapist Date