

Travis Howells, LPC

Teen Information and Informed Consent

Who I Am

Travis Howells, LPC offers professional psychotherapy and counseling services informed by evidence based practices at a master's level. I serve adults and adolescents. It is your right to have knowledge of my professional qualifications and you have been provided with a disclosure of my professional information.

Confidentiality

I take great care with all oral and written client information. Your information will be kept private in accordance with standards set by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). If cell phones are taken into the session they may not be used to record information without the consent of the therapist and client (and/or legal guardian).

There are legal requirements that specify certain conditions in which I would be required to disclose your name and/or your treatment. The requirements are:

- If I believe that you are a danger to yourself or others
- If I become aware of any involvement that you have in the abuse of any minors, elderly, or disabled individuals.
- If I receive an order from a judge to release your records.

Fees

The current fee for counseling services is \$150 per 45-60-minute individual or family therapy session. Other session lengths and fees are detailed further below. Changes in session time should be discussed with me in advance to assure availability. Fees may also apply to the preparation of assessment reports, telephone conversations, consultations, or meetings you have authorized as part of your counseling process. Payment is generally expected at the end of the session.

Client Responsibility

If you cannot attend a scheduled session, please give me a 24-hour notice of cancellation by email. After multiple no-shows or cancellations, you may be subject to termination of services. Please notify me within 24 hours if you need to cancel your appointment. Missed appointments will be charged to your account at **full cost**. Please be aware that insurance companies **do not** pay for missed appointments.

Supervision or Other Affiliations

Occasionally it may be necessary or helpful for your therapist so seek additional supervision or consultation regarding your treatment. During supervision and consultation your confidentiality will be maintained. The purpose of discussing your services will be to improve the care you receive.

Notice of Privacy Practices

You have the right to read the notice of privacy practices before deciding to sign this consent form. You may obtain a copy of the notice of privacy practices form at any time by request. You have the right to revoke this consent at any time with a written request.

Informed Consent

I understand that counseling may involve discussing relationship, emotional, psychological, and or spiritual issues that may be distressing. I understand that learning new skills to apply in real life can take time and effort. I do understand that this process is intended to help me. I understand that there is no perfect "cure" for relationship, emotional, psychological, and or spiritual issues. I understand my role as a client which includes honest participation in all sessions, complete homework assignments, and demonstrate a willingness to change. I have been given a fee schedule and I agree to be responsible for all fees associated with my counseling. I am aware that Travis Howells, LPC is a counseling service and that there are alternative treatment options available to me. I have read the client's rights and privacy practices. I will not use alcohol or drugs (legal or illegal) prior to counseling sessions. I understand that my participation is voluntary and I may leave at any time. I agree that I will discuss my intention to end services prior to ending them.

I understand that my son/daughter _____ is receiving counseling services from Travis Howells, LPC. I understand completely that the counselor is providing mental health treatment and is not acting as an evaluator or investigator of any kind. I further understand that Travis Howells, LPC is not conducting a custody or visitation evaluation for my child. I agree not to involve the counselor in any custody or visitation disputes as I understand that would not be in the best interests of my child's treatment relationship with the counselor and would be counter-productive to the therapeutic process. I agree not to involve the counselor in court proceedings regarding treatment of my child now or in the future nor will he be asked to share my child's records regarding any such proceedings.

Signing this document signifies that you give consent for Travis Howells, LPC to administer counseling services as necessary. This signed document shall remain in effect until it is revoked by client or guardian, at which time written notice must be given to withdraw existing consent. You acknowledge that you are responsible for all charges generated for services rendered.

A signature is required by all custodial parents/legal guardians:

I have read this document and agree to participate in treatment under the conditions described above.

Child name: _____

Child Signature _____ Date _____

Parent/Guardian: _____ Date _____

Parent/Guardian: _____ Date _____

Client Information *(all information is required)*

Last Name: _____ First: _____ Middle: _____

Is this your legal name? Y N

If not, what is your legal name? _____

Birth date: _____ Age: _____ Sex: _____

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Preferred Phone Number: _____

Can I (Travis) identify myself when calling or leaving a message at this number? Y N

Referred by: _____

Emergency Contact: _____

Relationship to client: _____ Phone number: _____

Insurance Information *(please provide a copy of your insurance card)*

Person responsible for bill: _____ Birth date: _____

Phone: _____

Is this person is not you, is it a client? Y N

Employer: _____

Employer Address: _____ Phone: _____

Primary Insurance: _____

Subscriber's name: _____ SSN: _____

Birth date: _____ Relationship to client: _____

Group #: _____ Policy #: _____ Co-pay: \$ _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Travis Howells, LPC or insurance company to release information required to process my claims.

Signature: _____ Date: _____