Mentoring & Counseling Center

Teresa Kline, MA, LPC

Licensed Professional Counselor

972-268-9258

Informed Consent Agreement

Training and Background of Teresa Kline

Experience in the Mental Health Field—since 2000.
Licensed by the Texas State Board of Examiners of Professional Counselors.
Master of Arts Degree in Counseling-Liberty University-2000.
Certificate-Light University-Addiction and Recovery-30 hours.
Certificate-Light University-Relationship Coaching-12 hours.

What to Expect

"My goal is to provide a space where you feel you are welcomed and accepted.
I am committed to providing you with the best quality of care. And based on the set of concerns you bring to the first session I will determine if I believe that I have the expertise to assist you with these concerns. If your primary concern is outside of my area of expertise, I will provide referrals for you.
Weekly sessions are routinely recommended with the option for twice weekly if needed."

Note: Specific treatment outcomes are neither implied nor guaranteed.

Confidentiality

It is your right that your sessions and your records about you are kept private. Your confidentiality is protected by the rules of the Therapist's profession, the Therapist's personal integrity, and state law--except for a few rare instances. Texas state law requires that you be informed that in certain cases your confidentiality is not protected, and your information may be disclosed to the appropriate authorities/ agencies. These cases are:

* If Therapist has reason to believe that you may harm yourself or others
* If Therapist has reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect or exploitation of a person who is elderly, or has a disability.

Or * If Therapist is ordered to disclose by state or federal courts.

Client Initials _____ **Therapist Initials _____**

Informed Consent Agreement (continued)

Sessions are 50 minutes each.

-How to request to reschedule/cancel/change appointment day/time:
Option #1: text or call 972-268-9258. **Option #2**: via email: mentoringandcounselingcenter@gmail.com

-We value your time and appreciate you choosing our office to assist you in your Mentoring/Counseling/Life Coaching needs. We have reserved time for you on your scheduled day/time and we request that you provide 24 hours in advance notice if you are unable to keep your appointment. **In the case that you do not notify the office in advance that you will miss your scheduled appointment, you will be charged a No-Show fee of $50.**

-Permissions for this office to communicate with you: Please initial all that apply. Voice Mail: ___Yes ___No **Email**: ___Yes ___ No **Text:** ___Yes ___ No

-In Case of an Emergency between sessions:
In case of an emergency, or if you need immediate assistance for any reason, please call the **24-hour crisis hotline @ 866-260-8000** (North Texas Behavioral Health Authority). To leave a non-emergency voice mail message with this office, please call 972-268-9258. Messages will be returned within 24 hours.

. . . . .

I have read and understand the information above.

_____ _____
Client Signature **Date**

_____ _____
Therapist Signature **Date**

CLIENT REGISTRATION:

Last/First Name _____

Home Address_____

_____**Zip Code:** _____

Phone/Cell _____ **Phone/Home**_____

Email Address _____

Age_____ **Date of Birth**_____/_____/_____ **Family Physician**_____

Current Medications: _____

_____

Have you been to counseling before? _____ **If so, When:** _____

Prior mental health diagnosis? ____**No** ____**Yes** _____

Have you ever been diagnosed with Diabetes?_____ **Thyroid Condition?** _____

Recent major illness? _____ **Additional health concern?** _____

Emergency Contact _____**Phone**_____

Referred by: _____ **Internet Search** ____ **Insurance Company** ____**Friends/Family**

. . . . . .

Clients Covered by Insurance: Please sign/date below:

Co-pay is payable at time of each session. Your Therapist will submit bill to the insurance company for the remaining portion of charges due. Your signature authorizes such payments to be sent directly to Teresa Kline, MA, LPC. Your signature also authorizes the release of information necessary to process the claim.

Signed: _____ **Date:** _____

Name: _____ **Date:** _____

Check the following if they apply to you for the past 14 days in a row:

----Low energy
----Poor concentration
----Hopelessness
----Problems getting to sleep
___Problems staying asleep
-----Crying spells
___Loss of interest
-----Sense of worthlessness
-----Excessive feelings of guilt
-----Easily agitated
-----Racing thoughts
-----Anxiety
-----Decreased appetite
___Increased appetite

Current thoughts of Suicide? ___yes ___no
Current thoughts of Homicide? ___yes ___no

What is your primary concern that influenced you to schedule this appointment?

_____

_____

What topics do you want to focus on in session?

-----Marriage/Family/Relationship(s)
-----Guilt/Shame
-----Anger Management
-----Grief/Loss_____
-----Family of origin
-----Alcohol/Substance Abuse
-----Decision Making
-----Other _____

What do you hope to accomplish as you attend session(s):

1. _____
   _____
2. _____
   _____
3. _____
   _____