Mentoring & Counseling Center

Teresa Kline, MA, LPC

Licensed Professional Counselor
972-268-9258

Informed Consent Agreement (Parent copy)

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 your Teen feels welcomed and accepted. And I am committed to providing your Teen with the best quality of care. Based on the set of concerns your Teen brings to the first session, I will determine if I believe that I have the expertise to assist them with these concerns. If your Teen's primary concern is outside of my area of expertise, I will provide referrals for you.

My goal is also to assist your Teen in reaching his or her desired goals. At the close of the first session, I will recommend frequency of sessions. As counseling progresses, parents are always welcome to reach out with any concerns. Although I do not routinely contact the parents, I do reach out when there is a concern in regard to possible need for referrals and/or in case of safety concerns.

Note: Specific treatment outcomes are neither implied nor guaranteed.

Confidentiality

It is your Teen's right that sessions and records are kept private. Your Teen's 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 Clients be informed that in certain cases confidentiality is not protected, and Client information may be disclosed to the appropriate authorities/ agencies. These cases are:

If Therapist has reason to believe that Teen Client may harm self or others
* If Teen Client reports being sexually abused.
* If Therapist has reason to believe that Teen Client is involved in or has knowledge of abuse or neglect of a child; or abuse, neglect or exploitation of a person who is elderly, or has a disability.

*In either case above, the Counselor is required to contact CPS/APS.

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

Parent/Guardian Initials _____ **Therapist Initials _____**

Informed Consent Agreement (Parent copy 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.**

Write your initials beside "Yes" or "No" below re. to giving permission for means of communications with your Teen re. appointments/scheduling:

Voice Mail: __Yes __No **Mail**: __Yes __ No **Email**: __Yes __ No **Text:** __Yes __ No

Write your initials beside "Yes" or "No" below re. giving permission for means of communications with you, the Parent:

Voice Mail: __Yes __No **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.

_____ _____

Parent/Guardian Signature **Date**

ADOLESCENT CLIENT REGISTRATION:

Parent/Guardian Information:

Name _____Phone_____

Email Address_____

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Adolescent/Client Information:

Last/First Name _____

Home Address_____

_____Phone:_____

Age_____ Date of Birth_____/_____/_____ Family Physician_____

Current Medications: _____

Referred by: ____Insurance ____Internet ____Family/Friend

Has client been to counseling before? _____ If yes, When? _____

Previous Mental Health Inpatient Episodes? _____ If yes, When? _____

Previous Mental Health Diagnosis: _____

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Clients Covered by Insurance Please complete/sign below:

Co-pay is payable at time of each session. This office 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.

Parent/Guardian Signature _____ Date _____

Name: _____ Date: _____/_____/_____

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