



Elizabeth Curl Reep, LCSW  
Children, Adolescent, & Adult Counseling  
Marriage & Family Therapy  
Service Members & Military Families

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**ELIZABETH CURL REEP, LCSW**

Elizabeth Curl Reep, LCSW ~ 817.715.2785 ~ ereep@reepcounseling.com

## CLIENT INFORMATION AND CONSENT

I welcome you! It is my desire to ensure that your participation in counseling will be a most productive and satisfying one. In order to facilitate a therapeutic relationship, I have set forth certain information which will enable you to make an informed consent to counseling.

### **Therapist**

My name is Elizabeth Curl Reep and I am a Licensed Clinical Social Worker. The Texas State Board of Social Work Examiners, 1100 West 49th St., Austin, TX 78756, (512) 719-3521, licenses me to provide mental health services. I am also a member of the National Association of Social Workers. I am in private practice and operate as an independent practitioner.

### **Mental Health Services**

While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you will achieve change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded conceptualizations of your life, relationships, circumstances, and future, 3) move toward resolving your concerns, and 4) forge a plan that promotes greater realization of your human potential, happiness, and success. As your therapist, using my knowledge of human behavior and the human change process, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you or I feel it would be helpful.

### **Appointments**

Persons are seen in the office on an appointment basis. Appointments may be made by calling (817) 294-6320. Since I maintain my own appointment calendar,

you will give your name and number to the receptionist and I will call you back for scheduling the appointment. Appointments are 45-minute sessions.

### **Number of Visits**

The number of sessions needed is variable and depends on many factors, which we will discuss in the session.

### **Relationship**

Your relationship with me is a professional and therapeutic one. In order to preserve this relationship, it is imperative that I have no other relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I care about helping you but I am not in a position to have a social or personal relationship with you. Gifts, bartering and trading services are specifically disallowed in the legal code of ethics in my profession. In the event that our paths cross in social or public settings, our therapeutic relationship comes first. In order to protect your confidentiality, I will not initiate a greeting.

### **Cancellations**

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged the customary fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment. When you make an appointment you are reserving a time. As your therapist, I have agreed not to utilize that time slot for any other purpose. If you fail to keep your appointment and fail to give adequate notice, I am unable to schedule another use for that part of my workday.

### **Payment for Services**

My standard fee is \$125 per session. For clients with TriCare Insurance or EAP coverage with an EAP company with which I am affiliated, I will file your insurance/EAP claims for reimbursement. However, you are responsible for any

deductible or co-payment at the time of session. In the event the insurance company fails to reimburse for services, you will be responsible for the entire fee. Payment for services may be made by cash, credit card or personal check. There will be a \$25 fee for returned checks.

Although it is my goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. Should you subpoena Elizabeth Curl Reep as a factual witness or involve her in court-related processes, you will be charged a retainer fee of \$1500, with a charge of \$240 every hour she is involved in case preparation, phone calls, travel, and witness time, etc. Should you issue Elizabeth Curl Reep without her approval (see above), the subpoena will be directly turned over to her attorney and a bill will be rendered to you for immediate retainer fee payment.

## Confidentiality

Discussions between a therapist and a client are confidential. 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 party is an 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 client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to my attention in the beginning of the first session when we discuss this matter further. By signing this information consent form, you are giving your consent for me to share confidential information with all persons mandated by law and with the agency that referred you and the managed health care company and/or insurance carrier responsible for providing

your mental health care services and payment for those services, and you are also releasing and holding harmless this therapist from any departure from your right of confidentiality that may result.

### Duty to Warn

In the event my therapist reasonably believes that I, the undersigned client, am in danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name	Relationship	Telephone Number
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I, the undersigned client, consent for my therapist to communicate with me by mail and by phone at the addresses and phone numbers I have provided on the personal information form, and I will IMMEDIATELY advise the therapist in the event of any change.

### Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of effort you are prepared to give to this endeavor.

### Therapist's Incapacity or Death

I, the undersigned client, acknowledge that, in the event my therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my files and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected

by my therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

### Emergency Services

I am unable to provide services 24 hours per day, seven days per week. In the event that you become in need of emergency services when I am unavailable, you may call 9-1-1 or go to the nearest emergency room. You may also contact the following: Tarrant County: Crisis Intervention – Fort Worth at (817) 927-5544; Jon Peter Smith Hospital Emergency Room at (817) 927-1110. Dallas County: Dallas Suicide and Crisis Center at (214) 828-1000; Parkland Psychiatric Clinic at (214) 590-5536 or the Parkland Emergency Room at (214) 590-8761.

### Consent to Treatment

I, the undersigned client, voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I, understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. However, premature termination may result in failure to achieve therapeutic outcomes.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

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Client

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Date

-----  
Parent/Guardian

-----  
Date

\_\_\_\_\_

Spouse

\_\_\_\_\_

Date

As witnessed by:

\_\_\_\_\_

Elizabeth Curl Reep, LCSW

\_\_\_\_\_

Date

\_\_\_\_ I understand that if my child has parents that are divorced and/or part of a joint custody arrangement, I must furnish Elizabeth Curl Reep with a copy of the custody agreement/divorce decree. (If applicable, please initial)

The therapeutic environment necessary for effective counseling services is disrupted when attorney's, judges and the legal system becomes involved.

\_\_\_\_ I agree that I will not disrupt the therapeutic environment by involving attorney's, judges or the legal system into the course of counseling for divorce, custody or visitation purposes.



## CLIENT FEE AGREEMENT & CANCELLATION POLICY

1. Standard fee for service is \$125.00 per session.
2. Payment may be made in cash, credit card or personal check.
3. As a courtesy, I will provide clients with an invoice with diagnosis and billing codes so that you may submit the invoice to your insurance company for reimbursement once payments have been received.
4. Payment plans are available if prior arrangements have been made.
5. There will be a \$25 processing fee on returned checks and denied credit cards. Additionally, following a check return cash, money order or credit card payments will be required for subsequent sessions.
6. Phone calls longer than 10 minutes will be charged at a rate of \$40 per half hour.
7. My normal method of payment will be:  
 Check  
 Cash  
 Credit Card

Appointment cancellations must be made within 24 hours prior to scheduled appointments. I understand that if I miss or cancel an appointment with less than 24 hours notice, I will be charged a \$65 cancellation fee.

Any exceptions will be discussed on an individual basis with your therapist.

I have read and understand the client fee agreement. I am responsible for all outstanding balances incurred by me including insurance deductibles and co-payments and unpaid claims. I also understand that payment is due at the time of session unless prior arrangements have been made.

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Client Signature

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Date

## CREDIT CARD AUTHORIZATION

I authorize Elizabeth Curl Reep, LCSW, Reep Counseling to process the listed credit card for payment of services.

Type of Credit Card:

Visa                  MasterCard                  American Express                  Discover

Name on Card \_\_\_\_\_

Number on Card \_\_\_\_\_

Expiration Date \_\_\_\_\_/\_\_\_\_\_

Billing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I agree that the above information is true and I understand that my card will be charged and I will be responsible for the fees.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## TriCare Insurance and EAP Clients

1. Standard fee for service is \$125.00 per session.
2. I am currently on the following Insurance and Employee Assistance Program Panels: TriCare, Ceridian/Military One Source/LifeWorks, EAP Consultants, WellPoint, and Anthem.
3. You are responsible for any deductible and co-payment or non-payment at the time of the session.
4. In the case that your insurance company does not cover charges, you will be responsible for unpaid claims.
5. Payment may be made in cash, credit card or personal check.
6. Payment plans are available if prior arrangements have been made.
7. There will be a processing fee on returned checks.
8. My normal method of payment will be:  
 Cash  
 Check  
 Credit Card

Primary Insured \_\_\_\_\_ D.O.B. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Insured ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Claims Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I have read and understand the client fee agreement. I am responsible for all outstanding balances incurred by me including insurance deductibles and co-payments and unpaid claims. I also understand that payment is due at the time of session unless prior arrangements have been made.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date