PATHFINDERS
COUNSELING AND CONSULTING

CLIENT INFORMATION AND CONSENT

Patient Responsibility

We consider our patients to be active members in the therapeutic treatment process. As an active member in your treatment, we ask you to closely read this document, ensure you understand the content, and ask any questions you may have. If the patient is a minor and not able to comprehend the content in this document, we ask the legal guardian to read it and ask questions. In this scenario, only the guardian is expected to sign the document. If the patient is a minor and able to comprehend the content in this document as written, it is expected that both the patient and the guardian will read it, ask any questions they have, and initial/sign the document.

Providers

The providers listed below are independently licensed psychologists or psychiatrists engaged in private practice providing mental health care services to clients directly and as independent contractors/providers for various managed care entities. In addition, as shareholder and employee of their companies, the undersigned mental health providers provide all mental health services through the below corresponding company titles.

Debra Archuleta, Ph.D.	M&L Behavioral Health Consultants, PLLC
Jennifer Forsberg, Ph.D.	Jennifer A. Forsberg, Ph.D., PLLC
Teresa Hughes, Ph.D.	TMH Total Mental Health, PLLC
Heather Parton, Ph.D.	Heather Parton, Ph.D., PLLC
Trudi Zaplac, J.D., Ph.D.	Trudi Zaplac, Ph.D., PLLC
Melinda Fierros, M.D.	Total Insight Psychiatric Services, PLLC

APPOINTMENTS

Scheduling Appointments

Appointments are made by calling (210) 202-0100 Monday through Thursday (and variable Fridays) between the hours of 9:00 a.m. and 5:00 p.m. We will respond to e-mail requests for appointments via phone the next business day.

Number of Appointments

The number of sessions needed to help you achieve your therapy goals depends on many factors and should be discussed with your provider.

Length of Visits

Most therapy sessions are 45 minutes, but may be longer for initial visits or psychological testing. Medication management sessions will vary in length from 15 to 120 minutes.

MENTAL HEALTH TREATMENT

Mental Health Services

We appreciate that it is not always easy or comfortable to seek help from a mental health professional. We hope your treatment experience will enable you to better understand your situation and feelings to allow you to meet the goals that you set for your life. The mental health provider, using knowledge of human development and behavior, will make observations about situations as well as suggestions for new strategies 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 treatment session if you feel it would be helpful or if this is recommended by your mental health provider. The success of your treatment depends on the quality of the efforts of both you and your provider, consistent attendance of treatment sessions, and your commitment to change. Ultimately, you are responsible for the lifestyle choices/changes that may result from treatment.

Risks of Therapy

Therapy is the Greek word for change. One risk of therapy is that you may learn things about yourself that you don't like. You may feel emotionally uncomfortable at times since growth often occurs when one experiences and confronts issues that induce sadness, sorrow, anxiety, or pain. After making changes in your thinking and/or behaviors, your friends and family may respond differently to you and it is impossible to predict their response. One risk of marital therapy is the possibility of deciding to divorce after reaching greater insight.

Relationship

An essential element of mental health treatment is the professional and therapeutic relationship with your mental health provider. It is different from other relationships in your life, such as with your family and friends, in that it allows an objective view of your concerns. In order to preserve this relationship, it is imperative that the mental health provider not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The mental health provider cares about helping you, but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the mental health provider.

After-Hours Emergencies

Emergencies are urgent issues requiring immediate action. If you experience a mental health emergency after hours, please go to the closest Psychiatric Hospital or Emergency Department. These facilities can assist you in getting an evaluation by a provider trained to evaluate the need for urgent care, including hospitalization. If hospitalization is necessary, please have hospital staff or a family member contact your mental health provider on the next business day. You may follow-up with your mental health provider after you are discharged from the hospital. Your mental health provider is not affiliated with any Emergency Department or hospital nor does your mental health provider have admitting privileges at any hospital. Your mental health provider does not provide services at any inpatient facility and cannot provide services to you while you are hospitalized.

PAYMENT AND CANCELLATION POLICY

The clinic will look to you for full payment of your account and you will be responsible for payment of all charges. Different co-payments are required by various group coverage plans. Your co-payment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the co-pay may be different for the first visit than for subsequent visits. You are responsible for and shall pay your co-pay portion of the undersigned mental health provider's charges for services at the time services are provided. It is recommended that you determine your co-payment before your first visit by calling your benefits office or insurance company.

Payment for Services due at the time of service if you are not utilizing health insurance.

PSYCHOLOGY: Child and Adult Therapy Services

Type of Session	Duration	Cost
Intake (first appointment)	60-90 min	**$175**
Follow-up sessions	45 min	**$140**
Psychological testing	Varies	**Varies**
Missed appointments/late cancellation charge	**N/A**	**$70**

PSYCHIATRY: Medication Management Services:

Type of Session	Duration	Cost
Child intake (first appointment)	120min	**$375**
Child Follow-up	30 or 60 min	**Varies w/a minimum of $125/250**
Adult intake (first appointment)	90 min	**$325**
Adult follow-up	30 or 60 min	**Varies w/a minimum of $100/200**
Patient-initiated between-session phone contact/refills*	10min	**$25/10min**
Missed appointments/late cancellation charge	**N/A**	**$100**

* If you have to cancel an appointment, please let us know at that time that you need a refill of your prescription and your psychiatrist will address this without a charge. However, if you call the office to refill a prescription in between appointments because of a missed or canceled appointment, there will be a $25 charge. You will need to:

- Provide the names of the medications that need to be refilled
- Provide the name and phone number for your preferred pharmacy
- Schedule a follow-up appointment if you do not already have one scheduled
- Pay the $25 phone refill fee at the time of the call, if applicable; if the contact is not about a refill, you will be charged in 10 minutes increments.
- **NOTE: Schedule II prescriptions require a paper prescription. If you require a refill of a Schedule II prescription, you will be notified by the clinic staff when the paper prescription is ready for you to pick up at the clinic.**
- Please allow **1-2 weeks** for phone- refill requests

In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the mental health provider's hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time of or prior to the time the services are rendered by the mental health provider.

Cancellations and No Shows
If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the missed appointment. A fee of **$70/$100** is charged for missed therapy/medication management appointments (respectively) or cancellations **with less than a 24-hour notice** unless it is due to illness or an emergency. Your credit card will be charged or a bill will be mailed if you do not show up for or cancel an appointment with less than 24 hours' notice.

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 of a party is in issue
- situations where the mental health provider has a duty to disclose, or where, in the mental health provider's judgment, it is necessary to warn or disclose
- fee disputes between the mental health provider and the client
- a negligence suit brought by the client against the mental health provider
- the filing of a complaint with the licensing board.

If you have any questions regarding confidentiality, you should bring them to the attention of the mental health provider when you and the mental health provider discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned mental health provider to share confidential information with all persons mandated by law, with the agency that referred you, and with the managed care company and/or insurance carrier responsible for providing payment for your mental health services. You are also releasing and holding harmless the undersigned mental health provider from any departure from your right of confidentiality that may result.

Duty to Warn (**Please provide a name and phone number. Initial at the end of the line**).
"In the event that the undersigned mental health provider reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the mental health provider to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel: _____

_____" (_____)

Initials

E-mail
E-mail is not considered a confidential means of communication nor is it monitored daily. Your individual provider may not utilize the company e-mail service and may not receive any messages sent to this e-mail address. Please do NOT e-mail your provider unless you have discussed this form of communication with your provider in advance.

Contact
I consent for the undersigned mental health provider and other clinic staff to communicate with me by mail and/or by phone at the address(es) and phone number(s) listed in the Patient Intake Questionnaire, and I will IMMEDIATELY advise the mental health provider in the event of any change.

Mental health provider's Incapacity or Death
I acknowledge that in the event the undersigned mental health provider becomes incapacitated or dies it will become necessary for another mental health provider to take possession of my file and records. By signing this information and consent form, I give my consent to allow another licensed mental health professional selected by the undersigned mental health provider to take possession of my file and records and provide me with copies upon request, or to deliver them to a mental health provider of my choice.

Consent to Treatment
I voluntarily agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned mental health provider 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 mental health provider at any time.

My initials on the below items and signature at the bottom of this document indicate that:

_____ I have both read and understand the information in this Client Information and Consent form.
_____ I have been given ample opportunity to ask questions and seek clarification of anything unclear to me.
_____ I have been offered a copy of and/or received a copy of the Client Information and Consent Form.
_____ I have been offered a copy of and/or received a copy of the current HIPAA Compliance Laws and Regulations and that I understand my rights under HIPAA.

_____	_____	_____
Client Name	Signature	Date

_____	_____	_____
Guardian Name (if client is a minor)	Signature	Date

as witnessed by:

Provider Name	Signature	Date