

## Life Guide Counseling Services



### **Introduction**

Welcome, and thank you for choosing Life Guide Services. I am dedicated to helping you increase your self-awareness and problem solving skills to be able to achieve success in the pursuit of your life goals. I strive to provide you with a safe, supportive, and nurturing environment which facilitates your personal growth and enhances your ability to cope with negative feelings. I look forward to a productive and positive working relationship with you, and I believe that, together, we can take on any challenges you are facing in your life.

I view psychotherapy as a journey. In this journey, I see the client as a person in a small boat struggling to navigate through fog, in troubled waters, in order to reach the safety of the shore beyond. The therapeutic process is the lighthouse that illuminates the way to the shore of a functionally healthy life. Said another way, I help clients by using effective therapeutic techniques to discover problematic patterns, attitudes, defenses, and underlying feelings, and dysfunctional upbringing that contribute to their unhappiness and problematic life patterns. In addition to discovery and awareness, clients also learn strategies to help them to cope and find appropriate solutions to their problems. This helps clients find their way out of the darkness of confusion and suffering, and into the positive light of a productive and meaningful life.

As a psychotherapist, I employ techniques and strategies from variety of approaches such as Cognitive Behavioral (CBT), Dialectical Behavioral (DBT), classic Behavioral, Gestalt, Relational, Transactional Analysis (TA), Mindfulness practices and many others, as appropriate for the situation and consistently with my education, training, and experience.

### **Therapeutic Expectations**

Effective psychotherapy requires a partnership between the therapist and the client. Mental and emotional well-being are achieved primarily through dedicated and effective teamwork in a warm and supportive environment. Mutual trust, openness, respect, and a nonjudgmental, accepting attitude are all important qualities of a good therapeutic relationship. A therapeutic partnership works well when there is a clear understanding of mutual expectations and the rules of engagement. The issues below need to be discussed and agreed upon by both parties in order to achieve such a working relationship.

### **What you can expect of me:**

- ~ To help you identify problem areas.
- ~ To help you set realistic goals in order to help improve your situation.
- ~ To review our progress together openly and regularly in order to evaluate the effectiveness of the therapeutic process and change course as needed.
- ~ To confront openly any lack of progress and to explore contributing factors.
- ~ To terminate therapy and make appropriate referrals when we mutually agree that our therapeutic partnership is not working in your best interest.
- ~ To maintain the highest standards of ethical and professional conduct set by the Texas Board of Examiners of Professional Counselors ([www.dshs.state.tx.us](http://www.dshs.state.tx.us)).

- ~ To NOT engage in a personal relationship or friendship with you, as this would be highly unethical and also counterproductive to the therapeutic relationship.
- ~ To maintain your confidentiality (refer to HIPAA, Notice of Privacy Practices) within the limits explained later in this document and HIPAA NPP (available on the website and in the office).

**Client's Initials** \_\_\_\_\_

**What is expected of you:**

- ~ To take the therapeutic partnership seriously and work hard on achieving your treatment goals.
- ~ To openly discuss any problems or concerns you might have with any behaviors or therapeutic techniques used at any time during our sessions. This is crucial in building a mutually trusting and open relationship.
- ~ To respect our professional boundaries and NOT to attempt to obtain information about our personal lives and relationships.
- ~ To avoid unsafe behaviors that are physically harmful/threatening to you or us either in session or elsewhere.
- ~ To NEVER engage in sexually inappropriate behaviors in the context of our professional relationship (any such conduct may result in termination of therapy).
- ~ To give at least **24 hours notice** if you must cancel a session, unless there is sudden serious illness or an emergency, otherwise you will be responsible for the scheduled session fee.
- ~ To openly discuss any concerns you might have about the therapeutic process, including exceptions to confidentiality, beginning with your first visit.
- ~ To pay your fee each session, unless we agree to other arrangements in advance.

State any other expectations not listed above that you would like included:

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**Client's Initials** \_\_\_\_\_

**Explanation of Confidentiality**

I regard the information you share with me with the greatest respect and will keep it strictly confidential except as authorized by you or mandated by HIPAA, state and federal law and the profession's ethical principles.

Circumstances that may prompt disclosure include but are not limited to:

- 1) Threats of suicide or homicide or if there is a probability of imminent physical injury by you to yourself or others. **Duty to Warn:** In the event that you have given me information and I reasonably believe you intend to cause serious and imminent physical harm to yourself or another person, you specifically consent for me to contact a responsible party to prevent harm to yourself or another person. This includes but is not limited to medical and law enforcement personnel and the following persons (unless you include names and contact information below, I can only just contact law enforcement and/or necessary medical personnel). **List the name, relationship and contact information of the individuals you trust with such sensitive information:**

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The information is to be provided at your consent to said person(s) only to prevent harm to you or another person. This authorization shall expire upon the termination of services of this provider.

- 2) Mandated reporting of any known or suspected abuse, neglect or exploitation involving a minor, elderly, or disabled person
- 3) Information required by law, including court subpoena and court order
- 4) Cases wherein you disclose sexual exploitation or contact with another mental health service provider
- 5) If you file and use your insurance benefits, your carrier may request your records with or without your knowledge
- 6) Information necessary for the purpose of training, supervision and consultation
- 7) Information released as outlined in the HIPAA Notice of Privacy Practices
- 8) Investigation by state or federal regulatory authorities.

Other than the exceptions (mentioned in items 1 through 9) or where mandated by state or federal law, **I will not release information about you or even acknowledge that you are a client and receive services at our facility without your full knowledge and a signed consent to release of information.**

Client's Initials \_\_\_\_\_

### **Appointments**

To make an appointment, you may email or call using the contact information provided to you by the referral source or at the office (also provided on the website: [www.lifeguidetexas.com](http://www.lifeguidetexas.com)). If you are unable to keep an appointment, please leave a voice/text message or email at any time to cancel or reschedule. **Cancellation must be done at least 24 hours in advance**, except in the event of sudden, serious illness or a life-threatening emergency. If we do not receive such advance notice, you will be responsible for the payment of fee for the scheduled session. **A fee of \$75.00** will be charged for any sessions canceled or unattended without adequate prior notice or proper justification.

Client's Initials \_\_\_\_\_

### **In Case of an Emergency**

Please be aware that **we do not provide 24-hour emergency services**. If you are experiencing a life threatening emergency, please contact **911** or go to the nearest medical emergency facility. If you are suicidal and therefore at risk of imminent harm to yourself, please contact the **24-hour Suicide and Crisis Hotline** at **214-828-1000** or **866-672-5100**.

### **How to contact your counselor for an appointment or in case of an emotional crisis**

I check my voicemails at regular intervals when feasible. You may leave a message at any time on my confidential voicemail at (214) 697-5557. I typically return calls between the hours of 8 am and 9 pm on weekdays. If you are in an emotional crisis and you cannot wait until your appointment to discuss

your problem, you may leave a message, stating the nature of your crisis. I will return your call as soon as I have a reasonable level of privacy and time to be able to talk with you uninterrupted.

### **Counselor's Absence**

When I am unable to serve you due to undergoing a medical procedure, on vacation, or going to be out of reach for any other reasons for an extended period of time, I will have a designated counselor to be on-call to provide you with professional advice or referral on the phone. This information will be provided to you prior to my departure.

### **Referrals**

As a client you have the right to withdraw from our agreed upon treatment process at any time and request a referral for any reason. As a counselor, I reserve the right to withdraw from the treatment process if your needs are outside or beyond my scope of knowledge and expertise or if I determine that I am no longer able to be helpful to you. In the event I initiate withdrawal from your treatment, I will provide you with appropriate referrals, which of course you are free to accept or decline.

### **Substance Use**

Therapy cannot be conducted if you are presenting impaired at the time of your appointment by being under the influence of alcohol or other mind-altering drugs. In other words, for therapy to work, you have to be able to be fully present in your session, to fully understand and remember the therapeutic interactions and discussions. Impairment may also occur with some prescription medications, if they are not taken according to the prescribing physician's instructions. If you arrive to your appointment in such an impaired state, **the appointment will be rescheduled and you will be held responsible** for the payment of fee for the session.

Client's Initials \_\_\_\_\_

### **Methods of Payment**

You may pay in form of **money order** or **check** payable to Shea Alexander, DBA Life Guide Services each time we meet, **unless we agree on other payment arrangements**. If you prefer to use online banking, for direct deposit (free service), we provide you with the account information you need to set up a **direct deposit/bill pay** to the Life Guide Services business account. Credit/Debit Cards are accepted with an addition of a 3% charge to cover additional costs to the practice.

### **Insurance Coverage**

I am an **in-network provider** for **Blue Cross Blue Shield PPO**. I am considered an **out-of-network provider** for **any other health insurance** and my fees will be covered at the **out of network rate**. I provide on-line electronic/direct billing for clients insured by **Aetna, Blue Cross/Blue Shield of Texas** and **Cigna Health Care**. You will only be responsible for your copay and deductibles for the mentioned health insurance providers. You are expected to get your benefit information prior to your first appointment. You will be responsible for the session fee at the time of service for the out of network insurers. However, you will be provided with the required billing statement to file your claim for reimbursement from your insurance payer.

Health insurance companies require that we provide you with a diagnosis of your mental health condition for which you are being treated before they agree to pay for your treatment. You will be informed of your diagnosis prior to submitting your statement to your health insurance company. Any

diagnosis made will become a part of your permanent health care records. Feel free to ask any questions about your diagnosis and discuss your privacy requirements.

**Explanation of Dual Relationships**

Although our sessions may be psychologically intimate, it is important for you to realize that we have a **professional relationship** rather than a social or a personal one. Our contacts will be limited to sessions you will arrange with me in advance. **Please do not invite me to your social gatherings, ask me to friend or follow you on social media, offer me personal gifts, ask me to write letters of recommendation or be a character reference for you, or ask me to relate to you in any way other than in the context of our counseling relationship.** It is my opinion as well as the opinion of the Texas licensing board that you are best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. As we work together, you will learn some personal information about me only in the context of what would facilitate and help with your progress and your counseling experience and not in any way to benefit me personally (appropriate and ethical self-disclosure). It is important for you to remember that you are experiencing me in our professional role. If we see each other in public, I will protect your confidentiality by acknowledging you only if you approach me first and only to greet you back. **This chance public encounter should not involve any discussion of our personal life and would not take the form of a counseling session.** All counseling sessions are scheduled in advance and with our prior knowledge and expectation of such services at a mutually agreed upon time.

**Counselor’s Incapacity or Death**

In the event that the undersigned counselor becomes incapacitated or dies, it will become necessary for another therapist to take possession of all of the files and client records of this practice. By signing this service agreement, you give your consent to allow another licensed mental health professional designated by the undersigned counselor to take possession of your file and records and to provide you with copies upon your request, or to submit them to another therapist of your choice. You will select a successor therapist within a reasonable amount of time (no more than 6 months in duration) and will notify the designated mental health professional of the need for transfer of your records.

**Treatment Plan**

As mentioned previously, I use a variety of treatment techniques within the limits of my training and expertise. There may be alternative ways to effectively treat the problems and concerns you are experiencing. It is important for you to discuss any questions you may have regarding treatment options and to have input into setting goals for your therapy. As therapy progresses and as your needs change, your goals for therapy and services may also change. We will address these changes as they occur and adjust your treatment plan accordingly as necessary.

Initial Diagnosis: \_\_\_\_\_ Previous Diagnosis: \_\_\_\_\_

Initial treatment goal(s): \_\_\_\_\_

\_\_\_\_\_

Proposed Interventions: \_\_\_\_\_

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Plan for continued treatment and/or referral(s): \_\_\_\_\_

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**Consent to Treatment**

I, \_\_\_\_\_, hereby voluntarily agree to receive mental health  
(Client's Name)

assessment and authorize the undersigned provider to offer such care, treatment and other services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment and any other services provided by the undersigned Life Guide Services Provider. I understand that I may stop any services that I receive from the undersigned provider at any time.

**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 and discussion regarding such issues has been provided to me to my fullest satisfaction.**

**My or my guardian's signature below is testament to my agreement to enter in this therapeutic relationship and fully accept the terms as indicated in this agreement to services:**

\_\_\_\_\_  
**Client's Official Name**

\_\_\_\_\_  
**Client's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**If under 18, Client's Guardian's Official Name**

\_\_\_\_\_  
**Guardian's Signature**

\_\_\_\_\_  
**Service Provider's Signature**

\_\_\_\_\_  
**Date**

**Complaint Procedure**

I encourage you to discuss any concerns or complaints directly with me. However, if you believe that I or any other counselor has treated you unethically or caused you harm, you may submit your grievance in writing and/or inform **Texas State Board of Examiners of Professional Counselors at 1100 W. 49th Street, Austin, Texas 78756, Phone: 512-834-6658, Hotline: 1-800-942-5540, Fax: 512-834-6789. Thank You!**