INFORMED CONSENT

PSYCHOLOGIST

THE UNDERSIGNED PSYCHOLOGIST IS LICENSED IN THE STATE OF TEXAS AND TREATS A DIVERSE RANGE OF MENTAL HEALTH CONDITIONS. SHE WORKS WITH BOTH ADULTS AND ADOLESCENTS.

NATURE OF THERAPY

DR. FUCHS' APPROACH TO THERAPY TAKES INTO ACCOUNT THE SPIRITUAL, PSYCHOLOGICAL, SOCIAL AND BIOLOGICAL DIMENSIONS OF THE CLIENT. THE RELATIONSHIP ESTABLISHED WILL BE CHARACTERIZED BY MUTUAL RESPECT, AND COLLABORATION. OUR MUTUAL GOAL WILL BE THAT YOU WILL GROW AND DEVELOP AND BECOME COMMITTED TO WORKING ON THINGS DISCUSSED DURING OFFICE SESSIONS AS WELL AS AT HOME. THE ULTIMATE GOAL IS THAT YOU BECOME INCREASINGLY ABLE TO IMPLEMENT YOUR AWARENESSES AND CHANGES WITH INCREASED CONFIDENCE AND SELF RELIANCE.

PSYCHOTHERAPY CAN HAVE TREMENDOUS BENEFITS WHILE ALSO HAVING RISKS. BECAUSE THERAPY OFTEN INVOLVES EXPLORING AND DISCUSSING UNPLEASANT ASPECTS OF YOUR LIFE, THERE MAY BE UNCOMFORTABLE FEELINGS THAT ARE EXPERIENCED WHICH CAN INCLUDE SADNESS, LONELINESS, ANGER, GUILT, FRUSTRATION AND HELPLESSNESS. ALTERNATIVELY, PSYCHOTHERAPY CAN HAVE TREMENDOUS BENEFITS. IMPROVED RELATIONSHIPS, GREATER SELF CONFIDENCE, OVERALL IMPROVED OUTLOOK AND SENSE OF WELL BEING, IMPROVED ABILITY TO RESOLVE TROUBLING MATTERS AND CONFLICTS, AND SIGNIFICANT REDUCTIONS IN DISSATISFACTION OR DISTRESS REGARDING ISSUES IN YOUR LIFE. IT IS IMPORTANT, HOWEVER, TO NOTE THAT IT IS IMPOSSIBLE TO GUARANTEE ANY SPECIFIC RESULT REGARDING

YOUR THERAPEUTIC GOALS. TOGETHER WE WILL WILL WORK TO ACHIEVE THE BEST RESULTS POSSIBLE.

APPOINTMENTS/CANCELLATIONS

APPOINTMENTS CAN BE MADE BY CALLING THE OFFICE NUMBER DIRECTLY OR THROUGH EMAIL CORRESPONDENCE INCLUDED IN THE CONTACT INFORMATION PROVIDED AT YOUR FIRST VISIT. PLEASE CALL TO CANCEL OR RESCHEDULE AT LEAST 24 HOURS IN ADVANCE OR YOU WILL BE CHARGED FOR THE MISSED APPOINTMENT. YOUR AR RESPONSIBLE FOR CALLING TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. IT IS IMPORTANT TO NOTE THAT IF YOU ARE FILING WITH YOUR INSURANCE CARRIER, YOU WILL NOT BE REIMBURSED FOR MISSED OR CANCELLED APPOINTMENTS.

PAYMENT FOR SERVICES

THE CHARGE FOR A SESSION WITH DR. FUCHS IS $165.00. PAYMENT IS DUE AT THE BEGINNING OF EACH SESSION. DR. FUCHS ACCEPTS CASH, CHECK, MASTER CARD AND VISA.

CONFIDENTIALITY

DISCUSSIONS BETWEEN A THERAPIST AND A CLIENT ARE CONFIDENTIAL. NO INFORMATION WILL BE RELEASED WITHOUT YOUR WRITTEN CONSENT OR UNLES MANDATED BY LAW. POSSIBLE EXCEPTIONS TO CONFIDENTIALITY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING SITUATIONS: CHILD ABUSE; ABUSE OF THE ELDERLY OR DISABLED; SEXUAL EXPLOITATION; COURT ORDERED DISCLOSURE OF INFORMATION; AND/OR AIDS/HIV INFECTION AND POSSIBLE TRANSMISSION. IF YOU HAVE ANY QUESTIONS REGARDING CONFIDENTIALITY, YOU SHOULD BRING THEM TO THE ATTENTION OF DR. FUCHS.

DUTY TO WARN

IN THE EVENT THAT THE UNDERSIGNED PSYCHOLOGIST REASONABLY BELIEVES THAT I AM A DANGER, PHYSICALLY OR EMOTIONALLY TO MYSELF OR TO ANOTHER PERSON, I SPECIFICALLY CONSENT FOR THE DOCTOR TO WARN THE PERSON IN DANGER AND TO CONTACT ANY PERSON IN A POSITION TO PREVENT HARM TO MYSELF OR ANOTHER PERSON, IN ADDITION TO MEDICAL AND LAW ENFORCEMENT PERSONNEL, AND THE FOLLOWING PERSONS:

NAME, TELEPHONE NUMBER, RELATIONSHIP TO YOU:

_____

_____

_____

THIS INFORMATION IS TO BE PROVIDED AT MY REQUEST FOR USE BY SAID PERSONS ONLY TO PREVENT HARM TO MYSELF OR ANOTHER PERSON. THIS AUTHORIZATION SHALL EXPIRE UPON THE TERMINATION OF MY THERAPY WITH THE UNDERSIGNED PSYCHOLOGIST.

AFTER-HOUR EMERGENCIES

EMERGENCIES ARE URGENT ISSUES REQUIRING IMMEDIATE ACTION. IF THERE IS A MEDICAL EMERGENCY, IMMEDIATELY CALL 911. YOU MAY ALSO CONTACT DR. FUCHS AT THE NUMBER YOU WERE PROVIDED AT YOUR INITIAL VISIT. DUE TO THE NATURE OF DR. FUCHS' WORK, SHE MAY NOT ALWAYS BE IMMEDIATELY AVAILABLE.

CONSENT TO TREATMENT

I, VOLUNTARILY, AGREE TO RECEIVE MENTAL HEALTH ASSESSMENT, CARE, TREATMENT , OR SERVICES AND AUTHORIZE THE UNDERSIGNED PSYCHOLOGIST 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 PSYCHOLOGIST AT ANY TIME. BY SIGNING THIS INFORMED 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.

_____ _____

Client/Parent Date

_____ _____

Psychologist Date