LINDA WHEELER MCCUNE M.S.
Licensed Professional Counselor
972.824.2121
17770 Preston Road, Suite D
Dallas, Texas 75252

CLIENT INFORMATION AND CONSENT

Qualifications

I am a Licensed Professional Counselor (#18222). I received my master's degree in Clinical Psychology from the University of North Texas at Denton in 1991. I am a member of The American Academy of Bereavement, and am a member of the American Counseling Association. I was employed by a private health services organization for 17 years and have been in private practice since April 2003. My experience has been in assisting clients with many issues, including: grief and loss, anxiety, depression, pain management, relationship conflicts, pre-marital counseling, stress management and building effective coping skills. My experience has been with individuals, groups, couples, families, and teens. I am a board approved supervisor and supervise counseling interns completing requirements for independent licensure. I am also a provider of continuing education credits (CEU Provider #1429).

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated or permitted 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 treatment facilities; sexual exploitation; AIDS/HIV and other communicable disease infection and possible transmission; court orders, criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, protect, notify or disclose; sexual exploitation by a mental health professional or member of the clergy, a negligence suit brought by the client against the therapist; the filing of a complaint with a licensing board or other state or federal regulatory authority; to regulatory authorities in connection with their compliance or investigatory responsibilities; to employees or agents of the practice for operational purposes, to a supervisor if the therapist is under supervision and for treatment consultations with other mental health professional when deemed necessary by the therapist.

In the event that the undersigned therapist reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for the therapist to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the following persons:

NAME **TELEPHONE NUMBER**:

_____

_____

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your therapy with the undersigned therapist.

FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT. By signing this Intake and consent form below you acknowledge receipt of a copy of the Notice of Privacy Practices. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form below, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated or permitted by law, with the agency that referred you and the managed 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 the undersigned therapist for any departure from your right of confidentiality that may result.

Contact Information

You consent for the undersigned therapist to communicate with you by mail, email and by phone at the following addresses and phone numbers, and you agree to IMMEDIATELY advise the therapist in the event of any change:
MAILING ADDRESS:_____
TELEPHONE NUMBER(S):_____
EMAIL ADDRESS: _____

Confidentiality in Couples Counseling

If individual counseling sessions are indicated, I will maintain confidentiality with each partner unless it is believed that information given to me is detrimental to the progress of couple therapy. If I am given information by one partner (including phone calls, or email communication) that appears to be an impediment to progress in couple therapy, I will encourage and support the partner with the undisclosed information to share the information in a conjoint session. I will not share this specific information without the partners consent, but if the partner refuses to share the information in a conjoint session, referral to another therapist is indicated. If information given in an individual session indicates that treatment outside my professional expertise is needed I will provide appropriate referrals.

Marital or Joint Therapy Records

If I participate in couples or joint therapy pursuant to which joint sessions are held with the undersigned therapist I consent for the undersigned therapist to maintain a single case file for all joint sessions and to release all information contained in the file maintained for joint sessions to any participant in the joint session upon request by a participant.

Counseling purposes, goals, and risks

Therapy is the Greek word for change. The practice of counseling by licensed professional counselors is for the purpose of utilizing interpersonal, cognitive, cognitive-behavioral, behavioral, psycho-dynamic, and affective methods and strategies to achieve mental, emotional, physical, and social development and adjustment throughout the life span. The therapist, using her knowledge of human development and behavior, 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 feel it would be helpful or if this is recommended by your therapist.

Risks of counseling may include discomfort, as feelings may be aroused pertaining to current issues. 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 the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting the goals of your therapy. As therapy progresses these may change.

Progress with counseling may not be guaranteed as it depends on many issues including: family interactions, relationship issues, work related issues, and social support. As a professional counselor, I will always strive to provide quality care for each client, and support clients in reaching resolution to the issues at hand.

The duration of treatment for clients varies. Some clients may need only a few sessions while some clients may need ongoing care over a long period of time. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. At the end of the evaluation process the undersigned therapist will be able to provide you with some first impressions of what therapy may include and a treatment plan to follow if both you and therapist agree to work together in therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with the therapist. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about procedures feel free to discuss them with the therapist at any time. If you have doubts your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion. Clients can discontinue therapy sessions at any time. It is recommended that clients participate in a termination session if they have decided to discontinue therapy. This allows for a review of progress, available time for closure, and any appropriate referrals if necessary. The client agrees to communicate to the therapist their decision to end therapy ____, ____ (initial).

Counselor Client Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. If the therapist encounters you in public setting, in order not to reveal your identity the therapist will not acknowledge your presence unless addressed by you client first. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

After-Hours Emergencies

Please know that your therapist and The Center do not provide twenty four (24) hour crisis or emergency therapy services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself go to the nearest hospital emergency room for assistance.

Contacting Your Therapist

Your therapist is often not immediately available by telephone. The office number, 972.824.2121, is answered by voice mail that the therapist will monitor from time to time throughout the day. Although the therapist is typically in the office during normal business hours she will not take calls when with a client. A reasonable effort will be made to return any call made during normal business hours on the same day it is received, weekends and holidays excepted. Messages left after hours or on weekends or holidays will normally be returned the next business day. If you are difficult to reach, please inform your therapist of times when you will be available.

Email and Text Messages

The undersigned therapist uses and responds to email and text messages only to arrange or modify appointments. Please do not send emails related to your treatment or therapy sessions as electronic communications are not completely secure and confidential. Any therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during your next therapy session. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any emails or texts received from you and any responses sent will become part of your therapy record.

Social Media

Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted.

Cooperation of Client

You shall keep the undersigned therapist advised of your whereabouts at all times, and provide the undersigned therapist with any changes of address, phone number, contact information or business affiliation during the time period which the undersigned therapist's services are required. You shall comply with all reasonable requests of the undersigned therapist in connection with therapeutic treatment. The undersigned therapist may, set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including without limitation: your refusal to comply with treatment recommendations, the undersigned therapist or staff is uncomfortable working with you or your failure to timely pay fees or deposits in accordance with this Intake and Consent Form, subject to the professional responsibility requirements to which the undersigned therapist is subject. It is further understood and agreed that upon such termination of services of the undersigned therapist, any of your deposits remaining in the undersigned therapist's account shall be applied to any balance remaining owing to the undersigned therapist for fees and/or expenses and any surplus then remaining shall be refunded to you.

Fees for Counseling Services

Fees are payable at the time services are rendered. Failure to pay fees for counseling will result in termination of treatment after appropriate notice and suitable referrals are provided ____, ____ (initial). The agreed upon fee for counseling services is _____.

If using health insurance, I am happy to check benefit information for you. The client is responsible for any deductible, copayments or coinsurance. The client is also responsible for any unpaid balance if for any reason your claim is denied by your health plan.

Cancellations: When you schedule an appointment time, that time is specifically reserved for you. If unable to keep an appointment, notification by phone 24 hours before scheduled time is required**. You will be charged the full fee for any missed appointments without 24 hour notice.** Third party payments will not cover the cost of missed appointments _____, _____ (initial).

Fees for court appearance or deposition, if required, shall be no more than $150.00 per hour, payable by the client. In the event that a client's records are ordered released by subpoena, a charge of $50.00 shall be assessed to the client.

These fees are subject to change upon sixty (60) days prior notice to you.

To ensure proper payment in the event of a no-show and/or late cancellation, the requested credit card information as specified below will be provided by you (the client/legal guardian). You also agree to pay the $20.00 check fee plus bank fees for any checks that are returned for non-sufficient funds.

I authorize Linda W. McCune to charge my MasterCard, Visa, or other approved credit card for any accrued balance (co-pays, deductibles, late cancellations, no-shows, check return fees, etc.).

MasterCard _____ Visa _____ American Express _____ Discover _____

Cardholder's Name: _____

Card Number: _____

Expiration Date (month/year): _____

Last 3 or 4 Digit Code found on the back of credit card (on front of card for AMEX) _____

Billing address (if different from home address): _____

Therapist's Incapacity or Death

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

Scheduling Appointments

Call 972.824.2121, or contact me at counselorlwm@yahoo.com, to schedule an appointment time. Appointments are available Monday- Thursday. Daytime appointments are available and the last appointment is offered at 6:00 p.m. Fees for counseling services can be paid with cash, check, or credit card at the time services are rendered. Standing weekly appointment times are available as requested and scheduling allows. If you would like a standing appointment time please let me know.

Consent to Treatment

I have read the information above and any questions I have were addressed. I voluntarily agree to receive mental health services and authorize the undersigned therapist to provide such services as are considered necessary and advisable.

By signing this Client Information and Consent form, I, the undersigned client (or parent), acknowledge that I have read, understood and agreed to be bound by all the terms, conditions and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Linda W. McCune M.S., LPC

- **If you would like a copy of this form for your records please let me know by initialing here ____, _____. One will be provided upon request.**

If for any reason you are dissatisfied with the services provided and wish to contact the counseling board to file a complaint, you may do so at the following address/phone number/email:

Texas State Board of Professional Counselors
1100 West 49th Street
Austin, Texas 78756
512.834.6658
LPC@dshs.state.tx.us