Patricia E. (Pat) Gossett, M.A., LPC
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500 Turtle Cove, Suite 220 Rockwall, Texas 75087

Please read this document carefully as it contains important information that affects you and our professional relationship.

COUNSELING AGREEMENT & INFORMED CONSENT

Thank you for choosing me, Pat Gossett, M.A., LPC, for your counseling needs. These documents are designed to ensure that you understand our professional relationship, provide me with your consent for counseling, & collect pertinent information that will assist me in the counseling process.

CONFIDENTIALITY

All communication between you and your counselor will be held in confidence in accordance with the law and professional standards and will not, except under the circumstances explained below, be disclosed to anyone without your written authorization. ***Recording of counseling sessions is prohibited by Client, any Collateral Participant, or Pat Gossett, M.A., LPC.*** Exceptions include, but may not be limited to, the following:

- imminent harm to self or others, including information regarding any sexually transmitted diseases
- suspicion of abuse or neglect of the elderly or disabled
- suspicion of abuse (sexual or otherwise) or neglect of children
- compliance with a court order to do so
- child custody case suits in which the mental health of a party is an issue
- fee disputes between the therapist and the client
- a negligence suit brought by client against therapist or filing of a complaint w/ the licensing board
- processing third party payer forms, obtaining payment for third party payers, answering required questions from third party payers in order for client benefits to continue ***(Please be aware, if you are filing with your insurance carrier, your carrier has the right to request from me a copy of your session notes at any time without your knowledge to conduct an internal audit. I cannot be held responsible for the confidentiality of records released in this way.)***

Please note that exceptions to confidentiality are extremely rare; however, if they should occur, it is my policy whenever possible, to discuss with you any action being considered. Legally I am not obligated to seek your permission, especially if I need to secure your safety or the safety of others. If disclosure of confidential information does become necessary, I will release only the information necessary to protect you or someone else.

Texas law requires Licensed Professional Counselors to notify medical or law enforcement personnel in the event of imminent harm to self or others. You may designate an individual that I may call in an emergency; however, please note that notification is not limited to that person and may involve medical or law enforcement personnel as deemed appropriate.

Please initial here that you have read and understand the above "Confidentiality" section_____

RECORD-KEEPING

If I terminate practicing as a counselor, it will become necessary for another counselor to take possession of my files & records. By signing this Agreement you are giving me your consent to allow another licensed mental health professional selected by me to take possession of all your records.

FEES / LENGTH OF SESSION

My fee per session is $100.00, payable by cash, credit card (Master Card, Visa or Discover only) or check, and is collected at the beginning of each session. Sessions typically last for 55-60 minutes. Your promptness will allow you to take full advantage of your appointments. I accept certain insurance company assignments. If I am a provider with your insurance carrier, I will file a claim for some amount of reimbursement through your carrier. You are responsible for payment of your portion at the time services are rendered. If your carrier requires that you meet a certain annual deductible dollar amount and you have not met that amount, you will be charged at the provider reimbursement rate of your insurance carrier per session. If I am not a provider for your insurance carrier and you wish to file a reimbursement claim, upon your request I will provide you with a receipt for all fees paid in order that you may do so. ***Be aware, I file insurance for clients as a courtesy. You are responsible for any and all charges for each counseling session appointment, regardless of insurance coverage.***

Be advised that insurance companies require that a diagnosis be given regarding your mental health before they will agree to reimburse a medical professional for services rendered. Any diagnosis made will become a part of your permanent medical records. Upon your request, I will inform you of the diagnosis that will be submitted concerning you to your insurance carrier.

You are responsible for keeping your appointments. When you set your appointment, that time is reserved just for you. If you are unable to attend your appointment I require a 24-hour cancellation/reschedule notice. This notice offers me the opportunity to give the appointment time to another client. **The cost for a cancellation of less than 24 hrs. or missed appointment is $100.00. Insurance cannot be billed for missed appointments and you are fully responsible for this charge.**

If I am subpoenaed by either a client or client's legal representative, the following fees apply:

For any subpoena that requires me to make an in-person statement or be physically present for any legal proceeding:

1. Preparation time (including submission of records): $200 / hour
2. Phone calls: $200 / hour
3. Depositions: $500 / hour
4. Time required in giving testimony $500 / hour
5. Mileage: $ 0.54 / mile
6. Time away from the office due to depositions or testimony $250 / hour
7. All attorney fees & costs incurred by me as a result of the legal action.
8. Filing a document with the court: $100
9. The minimum charge for a court appearance $5000

A retainer of $2500.00 is to be paid at least 48 hours prior to the court date. If the costs for the testifying process exceed the amount of the retainer then those fees will be billed to the client and/or their legal representative.

For any subpoena of client records, files or the production of any other written statements:

1. Preparation time for treatment summaries or production of other new documentation:
   $100 / hour (my standard rate for clinical services per hour).
2. Printing costs: $25.00 for the first 20 pages & $.50 per page thereafter.

All legal fees are due upon receipt of the invoice.

Please initial here that you have read and understand the above "Fees / Length of Session" section _____

AFTER HOURS EMERGENCIES

If you experience an emergency requiring immediate action after hours, you are instructed to call 911 or go to your nearest medical emergency room for assistance. I do not return any client communications on Sunday. Crisis management calls to me will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment.

Please initial here that you have read and understand this section_____

EMAILS / TEXT MESSAGES / TELEPHONE CALLS

Please limit text messaging and emails to matters having to do with scheduling of appointments or billing issues, and save all other matters for discussion during your scheduled session time (unless I have instructed you otherwise for special considerations).

Any phone calls lasting more than 10 minutes will be billed at $25.00 for the first 15 minutes, and in $25.00 increments for 16-29 minutes, 30-44 minutes, etc.

Any emails that are not related to appointments or billing issues will be billed at $25.00 per response from me.

Please initial here that you have read and understand this section_____

THE COUNSELING PROCESS AND PROFESSIONAL RELATIONSHIP

Because individuals and issues vary, length of treatment is hard to determine ahead of time. Some clients need only a few counseling sessions to achieve their goals while others may require much longer. Please note that it is impossible to guarantee any specific results regarding your counseling
goals. There is a chance that you will feel worse before you feel better. During the process, you may increase your level of awareness, possibly causing initial pain and anxiety. You may experience changes that could result in disruptions and turmoil. We will discuss and work through whatever changes you make. Together we will work to achieve the best possible results for you. If counseling is successful, you should feel that you are able to face life's challenges in the future without my support or intervention.
You can expect that therapy will end when you have received the maximum benefits or obtained what you were seeking. You have the right to end the counseling relationship at any time.

I would hope, however, that you would discuss this decision with me first. If you or I feel you are no longer benefiting from our time together, we will end the relationship by mutual consent.
You are best served while I am seeing you for counseling if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. Our contact will be limited to sessions you will arrange with me. *Please do not invite me to social gatherings, offer me gifts, or ask me to relate to you in any way other than in the professional context of our counseling*
sessions. If I should run into you outside the counseling office, I will not acknowledge you unless you first acknowledge me. This is in order to protect your privacy with regard to counseling. I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards.

Please initial here that you have read and understand the above "The Counseling Process" section_____

COMPLAINT

If you have any complaints, please discuss them with me. If you are not satisfied with the resolution of the problem, you have the right to call the Complaints Management & Investigations (1-800-942-5540), or write to Texas State Bd. of Professional Counselors, P. O. Box 141369 , Austin, TX 78714.

Please initial here that you have read & understand above "After Hours ER" & "Complaint" sections_____

I, the Client, understand my rights and responsibilities as described in this document and request Pat Gossett, M.A.,LPC, to provide counseling services to me.

_____ _____

Client Signature Date

_____

Client Printed Name

_____ _____

Client Address Client Telephone Number (Primary)

_____ _____

City, State, Zip Code Additional Client Telephone Number

_____ _____

Patricia E. Gossett, M.A., LPC Date

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CLIENT INFORMATION

Name_____ Employer_____
Male_____ Female_____ Position held_____
Home Address_____ Work Address_____
City_____ST____Zip_____ City_____St_____Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Employed: Full Time_____Part Time_____
Social Security No._____
Date of Birth_____Age_____ Email address_____

SPOUSE INFORMATION (If Applicable)

Name_____ Employer_____
Home Address_____ Work Address_____
City_____ST____Zip_____ City_____St_____Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Employed: Full Time_____Part Time_____
Email address_____ Date of Birth_____Age_____

EMERGENCY CONTACT INFORMATION

The information you provide below is your authorization for me to contact these individuals should I deem it an emergency situation and/or necessary for your safety, or the safety of others, during the course of your treatment with me. This authorization fulfills HIPPA requirements for consent to release information.

Psychiatrist Name_____ City_____ Telephone ___.____

Primary Care Physician_____ City _____ Telephone _____ Other _____ Relationship to Client_____

Other name contact telephone number _____

_____ _____

Your Signature ***Date***

Patricia E. (Pat) Gossett, M.A., LPC
500 Turtle Cove, Suite 220 Rockwall, TX 75087 214-909-0829

PATIENT CONSENT FOR USE AND / OR DISCLOSURE OF HIPPA DEFINED PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby stated that by singing this Consent, I
(Please print full legal name)
acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice ("Information and Informed Consent") includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out her health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change her privacy practices that are described in her Privacy Notice, in accordance with applicable law.

I understand and consent to the following means of contact as deemed professionally necessary by Provider:

Yes_____ No_____ Telephoning my home and leaving a message on my answering machine or with the individual answering the telephone

Yes_____ No_____ Telephoning my office and leaving a message on my phone mail or with the individual answering the phone

Yes_____ No_____ Telephoning my cell phone and leaving a message on my voice mail or with the individual answering the phone

Yes_____No_____ Leaving a text message on my cell phone

Yes_____No_____ Leaving an email message at this address:

_____

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice. My questions have been answered to my full satisfaction.

_____ _____ _____
Printed Name of Patient **Signature of Patient** **Date Signed**

Client Information

Client Name:_____ **Date:** _____

(Please Print)

- **People living in your home with you:**
  - Name: Age: Relationship:

    _____ _____ _____

    _____ _____ _____

    _____ _____ _____

    _____ _____ _____

    _____ _____ _____

- **Immediate family members (children, spouse) NOT living in your home:**
  - Name: Age: Relationship: City / State

    _____ _____ _____ _____

    _____ _____ _____ _____

    _____ _____ _____ _____

    _____ _____ _____ _____

- **Current health issues:**
  - Please list all physical, mental, and/or emotional issues for which you are currently being treated:
    - _____How long? _____
    - _____How long? _____
    - _____How long? _____
    - _____How long? _____
- **Current care:**
  - Medical doctors, NP, PA, Psychiatrist, Psychologist, Licensed Counselor currently seeing:

    Name: Specialty: City: Reason seeing:

    _____ _____ _____ _____

    _____ _____ _____ _____

    _____ _____ _____ _____

    _____ _____ _____ _____

- **Current prescription medications:**
  - Medication Name /Mg / Dose: Start Date (Mo/Year) Reason for medication:

    _____ _____ _____

    _____ _____ _____

    _____ _____ _____

    _____ _____ _____

    _____ _____ _____

- **Spirituality / Faith:** **By signing this "Client Information / Symptom Checklist" document, you indicate that you understand and agree that counseling sessions with Pat Gossett, LPC are based on Christian principals and the use of Biblical precepts, scripture verses and references are a natural part of this counseling process.**
    - What is your religious preference? _____
    - How often do you attend religious services? _____
    - Where do you attend? _____

Symptom Checklist

Please check all that apply, then please CIRCLE items that are especially bothersome to you.

Please check any of the following which are / may have been particularly stressful to you:

Recent	Past	
_____	_____	Job related stress
_____	_____	Marital conflict
_____	_____	Death or loss of loved one; Relationship to this person_____
_____	_____	Conflict with children
_____	_____	Children with behavior problems
_____	_____	Conflict with parent(s) or extended family
_____	_____	Feeling stress due to recalling memories of trauma or stress in my life
_____	_____	Family member with an alcohol or drug problem
_____	_____	Being abused by someone
_____	_____	Financial pressure

Any of the following symptoms for (*all* of these) MOST OF THE DAY, NEARLY EVERY DAY, FOR PERIODS LONGER THAN SEVERAL DAYS AT A TIME:

Recent	Past	
_____	_____	Depressed or sad mood
_____	_____	Loss of interest or pleasure in things I'm normally interested in
_____	_____	Difficulty going to sleep
_____	_____	Difficulty staying asleep or waking up too early
		What are the average number of hours you are sleeping per night? _____
_____	_____	Sleeping too much
_____	_____	Increased appetite / weight gain (Number of lbs you have gained: _____)
_____	_____	Decreased appetite / weight loss (Number of lbs you have lost _____)
_____	_____	Fatigue / Poor energy level
_____	_____	Decreased activity (work / social / physical / sexual – circle those that apply)
_____	_____	Poor concentration or slowed thinking
_____	_____	Thoughts of suicide
_____	_____	Excessive feelings of guilt or worthlessness

Any of the following symptoms for (*all* of these) MORE DAYS THAN NOT, FOR MONTHS AT A TIME:

Recent	Past	
_____	_____	Excessive anxiety or worry for no good reason
_____	_____	Trembling, twitching or feeling "shaky"
_____	_____	Muscle tension or muscle aches

_____ _____ Easily fatigued
_____ _____ Dry mouth
_____ _____ Dizziness or lightheadedness
_____ _____ Nausea, diarrhea, or other stomach problems
_____ _____ Frequent urination
_____ _____ Irritability
_____ _____ Trouble falling or staying asleep

Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

Recent Past

_____ _____ Panic attacks / anxiety attacks
_____ _____ Persistent worry that I will have a panic attack
_____ _____ Heart pounding or racing heart
_____ _____ Trembling or shaking
_____ _____ Sweating
_____ _____ Choking
_____ _____ Nausea or stomach problems
_____ _____ Feelings of unreality
_____ _____ Numbness or tingling sensations
_____ _____ Feeling of smothering or shortness of breathe
_____ _____ Fear of dying
_____ _____ Fear of going crazy or doing something uncontrolled
_____ _____ Chest pain or discomfort
_____ _____ Dizziness, unsteady feelings or faintness
_____ _____ Flushes, hot flashes or chills
_____ _____ Avoiding situations or places that may cause panic or severe anxiety

Any of the following symptoms for (*all* of these) MOST OF THE DAY, NEARLY EVERY DAY, FOR MORE THAN FOUR (4) DAYS AT A TIME:

Recent Past

_____ _____ Euphoric or “high” mood
_____ _____ Irritable mood
_____ _____ Decreased need for sleep without feeling tired
_____ _____ Increased energy level
_____ _____ Increased activity (work / social / physical / sexual – circle those that apply)
_____ _____ Thoughts speeded up or racing thoughts

Recent Past

_____ _____ Increased talkativeness or being much more socially outgoing
_____ _____ Making decisions too impulsively
_____ _____ Going on spending sprees

Check any of the following relating to your alcohol or drug use:

Recent Past

_____ _____ I’ve felt alcohol or drugs were causing a problem for me
_____ _____ I have felt guilty about my use
_____ _____ Others have annoyed me about my use
_____ _____ I have had a desire (or made unsuccessful efforts) to cut down or control my use
_____ _____ I’ve tried unsuccessfully to control my use
_____ _____ I’ve used alcohol or drugs more often or in larger amounts than I intended
_____ _____ I’ve had to increase my use of alcohol or drugs to get the desired effect
_____ _____ I’ve had problems with withdrawal (shakes, nervousness, insomnia, etc.) when

I've cut down or stopped using alcohol or drugs

_____ _____ I've been to a meeting of Alcoholics Anonymous, Narcotics Anonymous, or Celebrate Recovery (circle any / all that apply)

Any of the following disturbances in eating or maintaining normal weight:

Recent Past

_____ _____ Insistence on maintaining body weight below expected for age and height

_____ _____ Intense fear of gaining weight or becoming fat even though underweight

_____ _____ I feel "fat" even when others see me as underweight

_____ _____ Eating binges

_____ _____ Feeling of lack of control of eating during eating binges

_____ _____ Vomiting or using laxatives to prevent weight gain

_____ _____ Being over-concerned about body weight and shape

Check any of the following that apply:

Recent Past

_____ _____ I tend to do things on impulse which end up being damaging to me or others

_____ _____ I have mood swings (depression, irritability, anger) lasting up to several hours

_____ _____ I have tried to commit suicide

_____ _____ I have made cuts, burns, or other injuries to myself without wanting to kill myself

_____ _____ My mood often shifts from being either overconfident to having low self-esteem

_____ _____ I have a hard time sympathizing with other's pain

Recent Past

_____ _____ I often feel others do not understand me

_____ _____ I tend to get very hurt or angry when I am criticized or rejected by someone

_____ _____ I tend to need a lot of reassurance or approval from others

_____ _____ I am very concerned about my appearance

_____ _____ Others often expect too much of me

Check any of the following that apply at any time:

Recent Past

_____ _____ Hearing voices that sound real even though they are not actually there

_____ _____ Vivid voices in my head that do not seem like my ideas

_____ _____ Feeling that others might be putting thoughts in my head

_____ _____ Feeling others might be able to read my thoughts

_____ _____ Others feel I am too suspicious or paranoid

_____ _____ Feeling others might be talking about me

Any of the following problems relating to a past severe trauma or stress:

Recent Past

_____ _____ I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it

_____ _____ History of relatives hurting my physically or touching me in sexual areas

_____ _____ History of unwanted sexual contact

_____ _____ I have memories or dreams of a stressful event I have trouble putting out of my head

_____ _____ I sometimes have flashbacks of past events or I act or feel as though I am re-living a stressful event from the past

_____ _____ I try to avoid situations or people that remind me of a stressful event in the past

_____ _____ I have frequent nightmares

Any of the following obsessions or compulsions:

Recent Past

_____ _____ Excessive doubting, or repeated, forced unreasonable thoughts, images or sounds that I cannot get out of my mind

_____ _____ Urges to check things, wash things, or count repeatedly

_____ _____ Excessive concern about coming into contact with germs or dirt

_____ _____ Excessive concern with right / wrong or morality

_____ _____ Excessive need for things to be exact or symmetrical

_____ _____ Recurrent, excessive pulling out of hair on any area of the body resulting in hair loss

Please list any other CURRENT symptoms you may be experiencing that have not been listed above.

_____

_____

_____

_____

_____ _____

Client Signature **Date**

_____

Client Printed Name

COUNSELING GOALS

When beginning or re-entering the counseling process (individual), it is important to think about what you want to accomplish during our sessions together, as well as for yourself as you move through life. Questions to ask yourself might be: What will be present (either in you or in your life) that isn't there now? What behaviors will have changed or be adopted to bring healthier elements into your life and into your relationships?

Individuals: Please state your goals in a positive way. Be thoughtful about what you want to change in yourself. Remember when thinking about your goals, you cannot change others – only yourself.

Couples: If you are engaged in marriage counseling with your spouse, please list those specific issues regarding your relationship with your spouse that are problematic for you and in which you are seeking change.

List your counseling goals / problematic issues below. (You don't have to have six goals, or you can have more goals than 6. Use the back of this page if you need more space.) *Please don't rush this assignment and give ample thought to your answers!*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Name _____ **Date**_____