The Relationship Place of Dallas, LLC
Dr. Sonja Stutzman, Ph.D., LMFT, LPC

Professional Disclosure, Informed Consent, & Privacy Practices

Please initial each paragraph below in the available box acknowledging and indicating your understanding and acceptance of the terms:

_____ **Qualifications:** Sonja Stutzman, Ph.D., is a Licensed Marriage and Family Therapist and Licensed Professional Counselor in the state of Texas. Dr. Stutzman received her training at Iowa State University and conducted the majority of her internship at the Family Studies Center at The University of Texas Southwestern Medical Center.

_____ **Clients Rights:** As a client you are in control and may end therapy at any time, though it is requested that you participate in a termination session. Some clients need only a couple of sessions of therapy, whereas others need much more time, such as months or even years. In general, individual sessions last approximately six to ten sessions, couples sessions last approximately 8 to 14 session, and family sessions last 8 to 12 session. This varies depending on what you and the therapist feel are the needs of those involved in therapy and when goals are reached. The counseling services provided will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Boards of Examiners of Marriage and Family Therapists and Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time for any reason you are dissatisfied with the services you are receiving through The Relationship Place, LLC, please let Dr. Sonja Stutzman know so that existing issues can be worked through. If your concerns still persist, you may report your complaints to the Texas Boards of Examiners of Licensed Marriage and Family Therapists and/or Licensed Professional Counselors. Should you need to file a formal, ethical complaint against a license holder, you may contact the Texas Department of State Health Services' Complaints Management Section at 1-800-942-5540

_____**Notice of Privacy Practices and Confidentiality**: The process of therapy requires the collection and sustaining of protected health information (PHI). It is a priority to keep as much of this information confidential as possible. Communications with a therapist in treatment are privileged and may not be disclosed without your written permission, except as required by law. The following are situations in which a mental health professional is required by law to reveal information obtained during therapy to other persons or agencies without the client's permission: (a) If a client threatens bodily harm or death to him/herself or to another person; (b) If a court of law issues a legitimate court order (signed by a judge), the practicing therapist will be required by law to provide the information specifically described in that order; (c) If a client reveals information relative to child abuse, child neglect, or elder abuse (past or present). Also, (a) If a client presents to therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; (b) If any sexual improprieties by a former therapist are reported, the therapist must report this to the state licensing board; (c) If any sexual improprieties by clergy are reported, the therapist must report this to the district attorney; (d) If a client is seeking reimbursement through an insurance company, it will be necessary to reveal confidential information to them; (e) Banks and credit card companies may be made aware that a person is receiving services from Dr. Sonja Stutzman due to check or credit card processing; (f) If a client files a complaint or malpractice suit against a therapist, the therapist reserves the right to use his or her records to defend him or herself in court. A client's records may also be used to sue for delinquent payment. A client's

personal, written consent is required should the need arise for one's information or records to be shared for any other reason than those required by law as stated above.

_____ **Record Keeping:** Records are kept for 8 years after the termination of therapy, or six years after the youngest person turning 18 occurs (i.e., when the person turns 18 + 8 years). All records are kept in either a double locked cabinet or under a lock on a computer.

_____ **Communication:** Communication through telephone, and other electronic means is not completely confidential to the extent that spyware and other dangerous hardware can gain access to protected material. It is recommended that clients keep electronic communication brief and vague. Please do not write any information in an email which you would not want others to know. Information communicated via phone or email may become part of your client file.

_____**In Cases of Emergency:** I am aware this counseling office is not an emergency or 24 hour service. In the case of an emergency, clients are requested to call their primary care physician or 911.

_____**Duty to Warn:** In the event that the undersigned therapist reasonably believes that you are in danger physically, to yourself or another person, I consent for the therapist to warm the person in danger and to contact the following person, in addition to medial and law enforcement personnel.

Name: _______________________________ Telephone Number: ______________________

_____**Effects of Therapy**: The exact nature of therapy cannot be predicted. Specific results cannot be guaranteed in therapy, and at times it may feel as though things are getting worst. If any time you would like to discuss the possible positive and negative effects of entering, not entering, continuing, or not continuing therapy you may do so. Risks of treatment include potential for both emotional and relational discomfort related to issues discussed during the counseling process. I understand I am free to discontinue therapy at any time.

_____**Counseling Relationship:** The ethical code of Marriage and Family Therapists prohibits dual relationships during the course of therapy. This means the therapeutic relationship is a professional relationship and all services provided are professional therapeutic services. In order to further protect your confidentiality, if you see me in public I will not approach you, but, if you feel comfortable, you may approach me first.

_____ **Incapacitation/death:** I acknowledge that, in the event the undersigned therapist become incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing a 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.

_____**Referrals:** There are times when referrals are appropriate to therapy. Should you and/or I believe a referral is necessary, I will provide at least two alternatives to treatment that I feel may better assist you. You will be responsible for contacting and evaluating the referrals and alternatives.

_____ **Request for paperwork:** Should you request a copy of your counseling records, please be aware that a record preparation fee ($.35/page, minimum of $30.00) will be incurred and a “Release of Records” form must be signed by all clients ages 18 and over that participated therapy with you. An overall counseling summary, dates and times of sessions, in lieu of records, will be provided monthly upon request. If records are subpoenaed, this does not indicate an automatic release of records and we may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client’s best interest.

_____ **Information:** In the case of marriage or family counseling, I will keep confidential (within limits cited within this document) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress

_____**Court:** The professional relationship that is developed in therapy is not conducive to appearing and testifying in court. I do not agree to serve as an expert witness or to provide testimonial services for you and you agree not to cause me to be used in this way. Should you or your attorney subpoena me as a factual case witness or involve me in court-related proceedings, you agree to pay to Dr. Stutzman $255.00 for every hour of my time involved including case preparation, phone calls with attorneys, travel and witness time. You further agree to pay a retainer fee of $1,500.00 at the time a subpoena is served, to be applied toward these charges. If a subpoena is issued for me it will be turned over to an attorney and I will consult with that attorney as necessary.
A bill will be rendered to you for immediate payment when a subpoena is issued. Please let me know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motivations.

_____ **Cancellations:** In the event that you will not be able to keep an appointment, a 24 hour notice in advance is requested in order to avoid billing of the session. If no notice is given, a regular session fee will be billed to you. If less than 24 hour notice is provided at $43 will be charged to you.

_____**Financial Agreement:** Payment of $85 per 45 minute therapeutic session is due in full at the beginning of services rendered, unless previous arrangement have been made. Any phone call lasting more than 10 minutes will incur to a $2 per minute charge following the first 10 minutes. All returned checks will incur at $25.00 return-check fee.

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I certify the information which I have provided on this form is true and accurate. I have read and understand the above rights, authorizations, and responsibilities and have signed below to indicate my agreement with these terms. I have also read and understood the *Notice of Privacy Practices* and have signed below to indicate my agreement with its terms as well.

_______________________________________ ___________
Client and/or Guardian's Signature Date

_______________________________________ ___________
Client Date

_______________________________________ ___________
Client Date

_______________________________________ ___________
Client Date

_______________________________________ ___________
Client Date

I authorize Dr. Sonja Stutzman, Ph.D., LMFT, LPC to charge my MasterCard, Visa, or American Express credit care for any accrued balance (co-pays, deductibles, late cancellations, no shows, check return fees, etc.).

☐ MasterCard ☐Visa ☐American Express

Carholder's Name: ____

Card Number: ____

Expiration Date (month/year):______/________

Zip Code: ___________________

Last 3 or 4 Digit Code found on the back of the credit card: ___________________

Signature: ____ Date:________