SFG Counseling
Adults, Teens, & Women's Issues

9707 Talleyran Cove,
Austin, TX 78750
(737) 777 - 8452
Suzanna Finnegan Guyton Counseling LPC-S

Today's Date: ___/___/___

Client Information

Client Name (Please Print) | Marital Status S M W D P Sep. | Date of Birth

Client Home Address | City/State | Zip Code | Home Phone # Cell Phone #

Client's Employer | Occupation (Indicate if Student) | How long employed? | Business Phone #

Employer's Address | City/State | Zip Code | Client Driver's License #

In case of emergency, contact (name, relationship, and phone number):

Spouse's Name

Spouse's Employer | Occupation (Indicate if Student) | Business Phone #

Employer's address | City/State | Zip Code

Who referred you to this practice (or how did you find us)? | Primary Care Physician

Insurance Information

Note: Please provide insurance information only if you have made arrangements with our office to file your insurance.

Person responsible for payment, if not above Address / City / State / Zip Code | Phone #

Insurance Company Name | Policyholder Name | Date of Birth

Insurance Phone # | Insurance Authorization #

Insurance ID #/Subscriber# | Insurance Group #

If Client is a Minor or Student

Mother's/Guardian Name | Address / City / State / Zip Code | Home Phone #

Mother's/Guardian Employer | Occupation (Indicate if Student) | Business Phone #

Employer's Address / City / State / Zip Code | Mother's/Guardian Driver's License #

Father's/Guardian Name | Address / City / State / Zip Code | Home Phone #

Father's/Guardian Employer | Occupation (Indicate if Student) | Business Phone #

Employer's Address / City / State / Zip Code | Father's/Guardian Driver's License #

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Email & Texting Consent

HIPAA Regulations and my professional code of ethics require that I keep your Protected Health Information private and secure and I am committed to doing so. While email and texting is convenient to communicating regarding administrative matters,it is not entirely 100% secure. Potential email risks include:

1. Missed delivery of email to an incorrectly typed address
2. Email can be “hacked”, giving a third party access to email content and addresses
3. Email providers (Gmail, Yahoo, Hotmail, etc) retain a copy of each email in their systems, where it could be accessible to employees.

For these reasons, I will not use email or text to discuss clinical, personal information (session content).

If you are comfortable with it, I will use email text to reference scheduling.

If you are not comfortable with it, we can communicate by phone calls instead.

Please indicate your personal preference below and sign the following:

I DO or I DO NOT consent to the use of email/text for administrative matters by my therapist Suzanna Finnegan Guyton. If given, consent will expire 2 years after last appointment. This means I will not contact you by email although you are welcome to contact me and I can reply briefly if you do.

_____ ____/____/____
Client / Patient Name Date

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Client Consent to Treatment

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that the therapist can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

My goal of is to provide the most effective therapeutic experience available to you. If at any time you feel that we are not a good fit, please discuss this matter with me to determine if transferring to a more suitable Therapist is right for you.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 55 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call our office at 512-698-2588 at least 24 hours in advance, whenever possible. This will free your appointment time for another client.

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$120.00
	Regular Office Visits (50 minutes) (Individuals, Couples & Play Therapy)	$100.00
	Written Reports (insurance companies, supervisors, etc. pro-rated at	$60.00

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, I will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every

attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, your Therapist's pager number will be given on our voice mail system. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency dept. for help. When your Therapist is out of town, you will be advised and given the name of an on-call Therapist.

CONFIDENTIALITY: I follow all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated 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 mental health facilities; 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 or disclose; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. 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, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the 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 from any departure from your right of confidentiality that may result.

Duty to Warn / Duty to Protect: if my therapist believes that I am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel appropriate:

Name 1 _____ Telephone number _____

Name 2 _____ Telephone number _____

[Signatures and Consent to Treatment on Next Page]

Consent to Treatment: By signing this client information and consent form as the client or guardian of said client, I knowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or requests clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment treatment and services and I understand that I may stop such treatment at any time

_____ ____/____/____
Signature of Client / Parent Date

_____ ____/____/____
Signature of Spouse / Partner / Parent Date

_____ ____/____/____
Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ ____/____/____
Client / Parent Date

I authorize the payment of medical benefits to the provider of services.

_____ ____/____/____
Client / Parent Date