



## HK Counseling Services, LLC

Harpreet 'Preeti' Kaur, LCSW, CART  
Missouri City, Texas

713-484-9175

hkounseling@outlook.com  
Hkcounselingservices.com

### **Client Informed Consent for Treatment**

#### **SCOPE OF PRACTICE:**

I am a Licensed Clinical Social Worker (TX # 37335) and I am currently in a private practice, providing individual, couple, and marriage/family therapy for clients 12 years and older. I am also a Certified Anger Resolution Therapist, and am able to provide private and/or group therapy working with person(s) having difficulties in managing/controlling their anger.

Since not one therapeutic modality is suitable for everyone or for every purpose, I am likely to draw on various psychological approaches during the therapeutic relationship with you. These approaches may include, but are not limited to, Cognitive Behavioral Therapy, Mindfulness-based Cognitive Therapy, Motivational Interviewing, Interpersonal Psychotherapy, Solution Focused Brief Therapy, Dialectical Behavioral Therapy, Relational Psychotherapy, Systems/Family Therapy, or Psycho-Educational tools.

Mental health concerns addressed within the scope of my practice include: Depression; Low Self-esteem and Self-confidence; Relationship and Family Conflicts; Interpersonal Communication Difficulties; Behavioral Problems; ADHD; Cultural Assimilation Concerns; Life Transitions; Anxiety and Stress; Emotional, Physical, and Sexual Abuse; Trauma and Post Traumatic Stress Disorder (PTSD); Grief and Loss; Mood Disorders; Personality Disorder.

I am **not** authorized to prescribe any medication for you at any time. Depending on your symptoms and problems, medication may or may not be appropriate. In the event that a consideration of possible medication for psychological distress seems necessary, I will assist you in obtaining a medical or psychiatric evaluation.

#### **THE THERAPY PROCESS AND EVALUATIONS:**

A therapeutic process varies depending on several factors, including the particular problems you are experiencing. Approaches to treatment may include individual, couple, and/or family therapy. In order for the therapy to be most successful, you will need to work on things both during your therapy sessions and outside of therapy. The initial focus of therapy is on understanding the thoughts, feelings and life situations that are of present concern to you.

Therapy often leads to better relationships, solutions to specific problems, improved self-awareness and significant reductions in feelings of distress. At times, clients experience some discomfort while discussing unpleasant aspects of their life, experiencing feelings such as sadness, guilt, anger, frustration, and anxiety. It is important to recognize that these feelings may be natural and normal and are an important part of the therapeutic process. Although many clients find therapy to be helpful, there is no guarantee that therapy will accomplish your desired goals.

If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits. Goals for therapy are periodically reviewed and refined throughout therapy.

#### **CLIENT RIGHTS:**

1. You are entitled to information about my methods of therapy, techniques I use, and the duration of therapy (if it can be determined) as well as my fees. Do not hesitate to ask if you have any further questions on this.
2. You are entitled to terminate therapy at any time.
3. You are entitled to confidentiality (see section on Confidentiality below).



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### **CLIENT RESPONSIBILITIES:**

1. You are responsible for arriving at the time we have scheduled.
2. If you need to cancel a session, please allow for a 24 hour notice. Fees will be charged for missed appointments without 24 hours advanced notice.
3. You are responsible for on-time payment for services. Payment by cash, credit or personal check is expected at the time of the appointment. Returned checks that are not honored by your bank will incur a returned check fee of \$30.00.

### **TERMINATION PROCESS:**

Termination occurs when both the therapist and the patient mutually agree that the goals have been satisfactorily addressed or there is some other reason to terminate, including, but not limited to, the following:

1. After the first meeting, I will assess if I can be of service to you. I do not provide therapy for clients who, in my opinion, I cannot help. In that a case, I will give you referrals for other professionals that may be able to serve your needs better.
2. If at any point during therapy you are non-compliant (including unpaid fees), I reserve the right to terminate treatment. In such a case, I will provide you with referrals that may be of help to you.
3. You have the right to seek a second opinion from another mental health professional. Referral to other professionals, if requested or indicated, will be made at any time.

You have the right to terminate therapy at any time, however you are encouraged to discuss your concerns with me for at least one session before termination.

### **LIMITS ON CONFIDENTIALITY:**

With the exception of a few limited circumstances (listed below), you have the absolute right to confidentiality throughout your therapy with me. I cannot and will not disclose to anyone what we discuss in therapy or in outside phone contacts, or even that you are a client of mine, without your written authorization form that meets certain legal requirements imposed by HIPAA. Upon your written request, I will release information to anyone you specify unless I feel that releasing such information might be harmful in any way.

When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release client records only with signed authorizations from all the adults involved.

Disclosure is required or may be required by law when:

1. If I believe you are in imminent danger of harming yourself, I may legally break confidentiality in order to call the police or local crisis team. I would explore all other options with you before I took this step. If you were unable to take steps to guarantee your safety, I would have to take steps to insure your safety.
2. If I have good reason to believe you will harm another person, I am obligated to inform that person of your intentions and contact the local police.
3. If I have good reason to believe you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform the Administration for Children's Services or Adult Protective Services.
4. EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric



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care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the Intake form.

There are some situations where I may disclose information without either your consent or authorization:

1. If you are involved in a court proceeding and a request is made for information regarding your treatment, such information is protected by law. I cannot provide any information without your (or your legal representative's) written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
2. If a client files a complaint or lawsuit against me, relevant information regarding that client may be disclosed for the purpose of legal defense.

Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier.

### **TREATMENT RECORDS:**

Protected Health Information about you is kept in two sets of records: Clinical Record and Psychotherapy Notes. Your Clinical Record includes information about your reasons for seeking therapy, your diagnosis, treatment goals, medications, your progress, your medical and social history, your treatment history, any past treatment records received from other providers, reports of professional consultations, billing records, and reports that have been sent to anyone. Psychotherapy Notes contain the sensitive information that you may reveal in therapy. The law requires that I keep treatment records for at least 6 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way.

### **MINORS AND PARENTS:**

Unless the treatment is for suicide prevention, chemical addiction, or sexual, physical or emotional abuse, the law allows parents to examine a minor child's treatment records. Because privacy is often crucial to success, I will typically provide parents only with general information regarding the child's treatment. Before giving any additional information, I will discuss the matter with the child.

### **SOCIAL NETWORKING AND ONLINE SUPPORT:**

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

Although confidentiality and privacy are maintained professionally, confidentiality and privacy in psychotherapy sessions involving the internet cannot be guaranteed due to the insecure nature of internet connections. Please communicate with me via the communication methods selected on the Initial Intake Form completed by you.



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### **APPOINTMENTS and CANCELLATION POLICY:**

Your appointment time is reserved for you. Arriving late deducts time from your session. You will still be welcome to come in for the session, however due to respect for other appointments and the therapist, your session will end at the time previously appointed. It is your responsibility to notify me at least 24 hours in advance if you are unable to attend. If you are not able to provide this information in a timely manner, the following policies apply:

1. Appointment Late Cancellation (less than 24 hours): 50% of session fee
2. Missed Appointment (no notification): 100% of session fee
3. Cancellation with 24 hour notice: No charge

While it is often possible that I can arrange an alternative appointment time within the week for cancellations within 24 hours, the unavailability of such an appointment does not exempt the cancellation charges.

### **PAYMENT & FEES:**

My fee schedule is available for your review on my website [www.hkcounselingservices.com](http://www.hkcounselingservices.com). My fees range from \$80.00-\$125.00, depending on the services requested. You are expected to pay for services at the time they are rendered unless prior arrangements have been made. Services are rendered and charged to you, not to an insurance company. Upon request, I will provide you with a receipt to submit to your insurance company for "Out-of-Network" reimbursement. You may also incur charges for phone calls lasting more than 15 minutes, letters, and testing fees. There is a \$30.00 charge for returned checks.

### **CONTACT INFORMATION & EMERGENCY PROCEDURES:**

If you need to contact me between sessions, for any non-emergency matter, please call 713-484-9175. If you cannot reach me, please do leave a detailed voice message and I will try my best to return your call within 24 hours. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call 911 or go to your nearest emergency room.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ACKNOWLEDGE THAT YOU HAVE HAD THE OPPORTUNITY TO READ AND RECEIVE A COPY OF THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please bring one signed copy to your initial appointment and keep one for your records.**