# Sarah Shah, M.S., LPC

**Disclosure Statement**: In this statement I wish to present some information concerning my qualifications as a therapist, my office procedures and policies, and your rights as a client. When you sign this document, it represents an agreement between us. Please read this sheet and ask me any questions to help clarify for you the information presented.

**Licensure & Education**: I am licensed in the State of Texas as a LPC (Licensed Professional Counselor). I have completed a Masters Program in Counseling, passed the written examination given by the Texas State Board of Examiners of Professional Counselors, and completed 3000 hours under a supervisor. My license number is #81599.

**Psychotherapy Services & Approach:** I'm a relational therapist, meaning I believe our therapeutic relationship is the most important marker for change. Due to this, a majority of our early sessions are spent building rapport. I do a lot of active listening, reflecting back and summarizing what I'm hearing you say, and asking a ton of open-ended questions to help you introspect and build a deeper self-awareness. As our work deepens, I provide coping skills and tools as needed. We may laugh, sit with painful emotions together, and connect on parts of our shared stories -- our therapeutic relationship is one of collaboration and transparency. I am client-centered in my approach, meaning my clients guide their sessions because I truly believe they know where they need to go. Of course, I am happy to prompt and guide as needed. I believe therapy is about being, not doing. Although you may come to therapy with feelings of desperation for change, my role is to help you slow down to model a sense of grounding. Please let me know if you have any questions about these practices.

**Teletherapy:** I currently offer sessions through teletherapy - live online video conferencing - through my secure, online HIPPA compliant practice software. This allows me to provide services to residents across the state of Texas through the comfort of their own space. You will receive a link to the appointment 24-48 hours prior to the appointment through text and/or email. The telehealth consent form details teletherapy further.

**Appointments & Fees:** Sessions are 50 minutes in duration, unless otherwise discussed. My fee is $145 per 50-minute individual session, $165 per 50-minute couples or parenting session, and $245 per 80-minute couples or parenting session. My fee for phone sessions is $75 for 30 minutes and $145 for 50 minutes. For any letters requested and/or therapeutic documents, my fee is $145 per hour, prorated as needed. Please pay after each session. You are expected to come to all scheduled appointments. **If you are unable to attend an appointment, you must call or email me <u>24 hours</u> prior to your scheduled appointment time or you will be charged the <u>full fee</u> for the session(s) you have missed. If you are 20 or more minutes late to a session, I reserve the right to cancel and reschedule the session and charge the late fee.** If your case warrants me to perform case management, I will bill for that time at my hourly rate. This includes (and is not limited to) court preparations, consultation, and referral gathering beyond general practice. If your payment is declined, you have by the end of the work day of that week (5pm CST on Friday) to submit updated credit card information. If an updated credit card form is not completed by then, your future sessions will be canceled and you will be charged a late fee of $25 per week until the form is updated. How long you remain in therapy and the frequency of sessions is a matter best discussed while we work together to achieve your goals. It is your right to end therapy at any time, and when you decide to end treatment, it is in your best interest to discuss this with me beforehand.

**Insurance:** I am an out of network provider, meaning I do not accept insurance, to provide flexible, personalized, high-quality treatment for my clients with increased confidentiality. If you would like to use your insurance and work with me, I am able to provide you with a Superbill for you to file directly with your insurance for reimbursement. I do not communicate directly with your insurance provider, give any further documentation for them beyond the Superbill, or guarantee any reimbursement from your insurance company. If you would like a Superbill, I will need to give the identified client a diagnosis. Please let me know if you have any questions about this.

**Minors:** When working with minor clients, I will initially meet with all involved parents or caregivers in a session. Frequency of parent consultations will be determined in the first session and reassessed as needed. If you're a parent or guardian who is consenting to treatment for a minor, by signing this Agreement, you affirm that you're the parent or legal guardian of the child; that you have the legal right to consent to psychological treatment for the child; that there has not been a Divorce Decree or any other Court Order that limits your ability to consent to the child's treatment. If the child's parents are divorced or never married or separated, it is my practice to require BOTH parents to consent to treatment, in compliance with any Divorce Decree or Court Order that may be in place. I will also require a copy of the Divorce Decree or Court Order prior to providing any services to the child, and by your signature below, you agree to provide it immediately upon request.

**Communication Outside Sessions:** Appointments may be scheduled in person, over the phone, via text, or via email. **Email and text communication is ONLY used for arranging appointments.** I will not engage in discussions regarding your treatment using these means to maintain confidentiality. Telephone sessions may be arranged, but my usual fee will be applied. In case of a clinical emergency, please proceed to your nearest emergency room to seek immediate treatment or call 512-472- HELP or 911.

**Client Rights**: As a client, you have a number of rights concerning the course of your treatment with me. If, during the course of your treatment, you have any questions or concerns about your therapy, please raise those questions with me. This is your therapy, and you must feel that you understand both the direction and process of your treatment. If you are unhappy with the therapy you are receiving, you have the right to request a change in treatment. If needed, I will help you locate another therapist. If you wish to file a complaint, you may contact the Complaints Management and Investigative Section at 1-800-942-5540 or P.O. Box 141369 Austin, TX 78714.

**Client Files:** All client files are kept on my secure, HIPAA compliant practice management software. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

**Confidentiality**: As required by law, all information discussed during the course of psychotherapy with a Licensed Professional Counselor is confidential, unless confidentiality is waived by the client's signing of a release of information form. Under certain situations, however, confidentiality may not hold. These situations are:

1) Any suspected knowledge of child abuse, elder abuse or abuse of a handicapped person must be reported to the Child Protective Services Agency, or other appropriate agency.
2) If I believe your actions may constitute a danger to either yourself or others, this information must be reported to the potential victim or relevant authorities,
3) Information must be released to the courts if requested by a court subpoena under certain conditions.

As a note, if I see you in public, I will not acknowledge you unless you acknowledge me first to maintain the confidentiality of the services you are receiving.

**Social Media:** I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Twitter, Instagram, Pinterest, Google+, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and respective privacy. It may also blur the boundaries of the therapeutic relationship. I have active Facebook, Instagram, and LinkedIn accounts that are used primarily to post blogs and share articles that clients and other professionals might find interesting. You are welcome to view, like, or share articles and resources from my Social Media or Website, understanding that by doing so, you are risking your own privacy and confidentiality. If you choose to comment or like a post, I will not respond or acknowledge that comment in order to maintain a confidential therapeutic relationship.

**Testimonials:** You may find me on sites such as Yelp, Google Reviews, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. If you should find my listing on any of these sites, please know that the listing is NOT a request for a testimonial, rating, or endorsement from you as our client. The American Counseling Association's Ethics Code states that it is unethical for counselors to solicit testimonials. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on these sites whether it is positive or negative.

**Plan for Practice in Case of Death or Disability:** In the event of my death, incapacity or disability, I have made arrangements for another colleague to take over my practice, meet with clients, make appropriate referrals to other providers, if necessary, and take all reasonable steps to manage the practice for the benefit of my clients. Your signature below, authorizes my designee to contact you directly, and use and disclose your confidential mental health information and records for the stated purposes.

**Court Appearances and Fees:** I do not recommend using your therapy as a tool for court cases, as it will open up your or your child's personal process to dissection and interrogation. For the record, I will not agree to appear in court to testify in custody disputes or other legal matters, unless I am subpoenaed by a judge. If I am subpoenaed for records, you will be responsible for any administrative costs accrued related to court issues as well as my hourly rate for time spent. By your signature below, you acknowledge my position and agree to abide by my litigation policy. In the event that I must appear in court I must clear my schedule for the entire day because the time spent in court is unpredictable. If I am ordered to appear by a judge, regardless of which party issues the subpoena or requires me to testify, I require payment for services 72 hours in advance at the rate of $300 per hour. This includes travel, preparation, consultation, appearances and time on-call. If I am not called to appear, these fees for the time reserved and in preparation for appearance will still be due. You are responsible for any fees I incur related to your case (litigation issues, lack of payment, parking, printing/copying materials, etc.).

If I am required to testify in court or give a deposition in Travis County, I will charge an hourly fee of $300 per hour for a minimum of 4 hours ($1200) and this includes preparation time, travel time, and attendance at any legal proceeding. If I am required to testify in court or give a deposition outside of Travis County, the hourly fee will be $300 for a minimum of 6 hours ($1800). If the testimony or deposition exceeds 4 hours (in Travis County) or 6 hours (outside Travis County), there will be an additional charge of $300 per hour for every hour spent in court or deposition.

I will accept cash, money order, cashier's check, or credit cards for payment of time related to court appearances or deposition. NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES. You also agree by your signature below to execute and sign a Credit Card Authorization and provide a valid credit card to ensure payment for the time I must spend dealing with your litigation. By signing below, you expressly authorize me to run these charges to the credit card on file in our office unless you notify me that you intend to make payment by cash, money order or cashier's check.

# Acknowledgment of Review of Disclosure Statement

**For Accounting Purposes:**
I hereby authorize Sarah Shah, LPC PLLC to release my name, address, and payment information to their personal business accountant, who is under a non-disclosure agreement, for accounting purposes only.
Client initials: __________

**For Communication Purposes:**
I hereby authorize Sarah Shah, LPC PLLC to use these forms of communication to schedule or confirm appointments (initial each one that you approve):
___ Text ___ Phone ___ Email

**Please Initial**

_____ I understand the nature of the proposed therapeutic treatment and I give my informed consent for psychotherapeutic treatment by Sarah Shah, LPC.

_____ I understand that the fee for service is $145 for each individual session and $165 for each couples or parenting session.

_____ I have also been informed regarding fees related to legal proceedings and Sarah Shah, LPC PLLC's litigation policy and I agree to abide by it.

_____ I understand that the counseling session is **50** minutes in length, unless otherwise agreed upon.

_____ I agree to pay $145 for any missed individual and $165 for any missed couples or parenting sessions. I understand that if I am the individual who no-shows or late cancels a couples or parenting session, I am responsible for the late fee. To avoid a fee, please give 24 hours advance notice if you must cancel or reschedule an appointment.

_____ I understand that if I am experiencing a medical or mental health emergency, I have been advised to dial 911 or go to the nearest emergency room, and I agree to abide by these instructions.

I have reviewed and received a copy of Sarah Shah, LPC's Disclosure Statement. By signing below I agree to the stated terms.

| ______________________________ | ______________________________ |
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| Signature of Patient or Personal Representative/Guardian | Print Name of Patient or Personal Representative/Guardian |
| ______________________________ | ______________________________ |
| Description of Personal Representative/Guardian's Authority | Date |