Holloway Therapy Solutions
Felicia J. Holloway, PhD, LPC-S, LMFT-S
1301 E. Parkerville Rd., Suite B8
Desoto, Texas 75115
(214) 470-3195

Client Information and Consent

The following information is provided to you concerning the therapeutic services I, Felicia J. Holloway, PhD, LPC-S, LMFT-S, the therapist, render. Please carefully review this information.

The therapist is engaged in private practice providing mental health care services, including individual, couples, family, and play therapy, to clients directly and as an independent contractor/provider for various managed care entities. The therapist is a sole proprietor d/b/a Holloway Therapy Solutions.

Therapist Qualifications:

Doctor of Philosophy, Family Therapy
Master of Arts, Counseling
Bachelors of Science, Psychology
Licensed Professional Counselor - Supervisor
Licensed Marriage and Family Therapist - Supervisor

Concerns or Complaints:

An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:
Texas State Board of Examiners of Professional Counselors
1100 W 49th St Austin, TX 78756-3183 or
Call 800-942-5540 (to request the appropriate form or obtain more information about filing a consumer complaint against licensees only)

An individual who wishes to file a complaint against a Licensed Marriage and Family Therapist (LMFT) may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

or call 1-800-942-5540 to request the appropriate form or obtain more information

Therapist's Incapacity or Death:

For your convenience, the established plan for you to gain custody and control of your mental health records in the event of my death or incapacity, or the termination of my counseling practice is to contact Don Zablosky, MA, LPC-S, LMFT-S. Don Zablosky, MA, LPC-S, LMFT-S will have access to your records and can release them according to HIPPA regulations and Privacy Practices. Don Zablosky, MA, LPC-S, LMFT-S can be reached at:

Don Zablosky, MA, LPC-S, LMFT-S
1350 N. Buckner Blvd., Suite 220
Dallas, Texas 75218
(469) 855-9107

Holloway Therapy Solutions

Felicia J. Holloway, PhD, LPC-S, LMFT-S

Risks of Therapy:

I understand that therapy/counseling services may involve discussing relationship, psychological, and or/ emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with relationships. The success of the work I do with the therapist depends on the quality of my efforts and the therapist's efforts, and the realization that I am responsible for lifestyle choices/changes that may result from therapy.

Number of Visits:

The number of sessions needed in therapy depends on many factors which will be discussed with you during the therapy process. Your initial session will involve an evaluation of your needs and depending your circumstances further evaluative sessions may be required. At the end of the evaluation process, the undersigned therapist will be able to provide you with some first impressions of what therapy may include and a treatment plan to follow if both you and the therapist agree to work together in therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with the therapist. If at any point you would like a second opinion, your therapist will be happy to help you meet with another mental health professional.

Relationship:

Your relationship with the therapist is professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. The therapist cares about helping you, but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Goals, Purpose and Techniques of Therapy:

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting the goals of your therapy. As therapy progresses these may change. The therapist, in conjunction with you, will examine the issue you choose to address and help you explore possible perspectives/skills/behaviors to help resolve the issue. The therapist will utilize her knowledge of human development and behavior which may include aspects of the following therapy models/techniques, in hopes that you will be better able to understand your situation and feelings and move toward resolving difficulties you are facing:

Narrative Therapy, Cognitive Behavioral Therapy, Family Systems Therapy, Emotional Focused Therapy, Child Centered Play Therapy, Directive Play Therapy and/or Sand Tray.

I acknowledge that the therapist has discussed the overall goals, purpose and techniques of her mental health services. My therapist has satisfactorily answered my questions about her therapy/counseling services. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave therapy at any time, although I have been informed that it is best accomplished in consultation with the therapist.

Confidentiality:

I understand that what is discussed in therapy will generally remain confidential unless I give written permission to share information from my sessions by signing a release of information or unless mandated or permitted by law.

When participating in family therapy, be aware all files are considered family files and co-mingled which means that your file cannot be released without the written permission of everyone who was ever seen in therapy with you.

Holloway Therapy Solutions

Felicia J. Holloway, PhD, LPC-S, LMFT-S

Confidentiality conti.:

However, the therapist may share information about my therapy with the treatment team (when applicable) in the interests of providing quality care. My therapist has also informed me that there are other possible exceptions to confidentiality, which **may include, but are not limited to** the following:

1. Disclosure of child abuse
2. Disclosure of elder or dependent abuse
3. Child custody cases
4. Threats to harm oneself
5. Threats to harm others
6. If a court issues a subpoena
7. If you are required to be in therapy or be evaluated by a court order
8. If you claim harm to your mental or emotional state in a legal proceeding
9. A filing of a complaint with a licensing board or other state or federal regulatory authority
10. If required for third-party reimbursement

By signing this consent form below, you are giving consent to the therapist to share confidential information with all persons mandated or permitted by law, with the agency that referred you, and the managed care and/or 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 for any departure from you right of confidentiality that may result.

Duty to Warn:

In the event that the therapist reasonably believes that you ae a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for the therapist to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the following persons:

Name Telephone Number

_____

_____

Records:

Records of any services you receive are maintained in paper files locked within filing cabinets and/or in a secure password protected computer database. This database has the following features to support the confidentiality of your records:

- Certified HIPAA- & PCI-Compliant, encryption, firewalls to protect servers, data is backed up regularly, and strong passwords are required to enter database

Records are destroyed approximately seven years after you complete counseling or seven years after a minor's date of majority.

Holloway Therapy Solutions

Felicia J. Holloway, PhD, LPC-S, LMFT-S

Text/Email/Mail/Phone Communication:

Although you may choose to contact the therapist via text/email about such matters as rescheduling or canceling an appointment, please note that

- Your email/text may not be checked regularly.
- Your email/text may inadvertently be missed altogether.
- Do not send emails/texts related to your treatment or therapy sessions.
- Any therapy related questions or issues will be dealt with during your next therapy session.
- Emails or texts received from you and any responses sent will become part of your therapy record

_____ (initial) Email/text is not a secure or confidential means of communication

_____ (initial) I agree to receive text/email concerning rescheduling or canceling an appointment only at the following:

Email: _____ Phone Number: _____

_____ (initial) I agree to receive mail at the following:

Mailing address: _____City/State/Zip Code: _____

_____ (initial) I agree to IMMEDIATELY advise the therapist in the event of any change to my mailing address, telephone number or email address

Bearing this in mind, sensitive matters should be handled during face-to-face conversations at your appointment time rather than by phone/email/text.

Your therapist is often not immediately available by telephone. The office number, 214-470-3195, is answered by voice mail that the therapist will monitor from time to time throughout the day. The therapist will not take calls when with a client. A reasonable effort will be made to return any call made during normal business hours on the same day it is received, weekends and holidays excepted. Messages left after hours or on weekends or holidays will normally be returned the next business day. If you are difficult to reach, please inform your therapist of times when you will be available.

Fees/Appointments:

The fee for each 1 hour session will be $125(first visit only)/$100 each additional visit, and is to be paid at the time of therapy session.

Appointments are made by calling 214-470-3195.

Sessions are 55 minutes in length.

I have been informed of the cancellation policy, which states that I will pay half the normal fee if I fail to show for the appointment or cancel a session with less than 24 hours of notice. Third Party payments will not usually cover or reimburse for missed appointments

Holloway Therapy Solutions

Felicia J. Holloway, PhD, LPC-S, LMFT-S

Emergency Situations:

Please note your therapist does not provide twenty-four hour crisis or emergency therapy services.

In the event of an emergency, I have been informed to call 911 or go to the nearest emergency room.

In addition, if I experience a mental health emergency/crisis, I have been informed that I should contact one of the following: Crisis Line 972-233-2233 Suicide Line 1-800-273-8255

Consent for Treatment:

I hereby, voluntarily, consent to receive and/or consent to have the children in my legal custody to receive mental health assessment, care, treatment, or services, and authorize Felicia J. Holloway, PhD, LPC-S, LMFT-S to provide such care, treatment, or services considered necessary and advisable.

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through the undersigned therapist at any time.

By signing this Client Information and Consent form, I, the undersigned client (or parent), acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Name: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

As witnessed by:

_____ Date: _____

Felicia J. Holloway, PhD, LPC-S, LMFT-S

Therapist