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
Child

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:
Texas State Board of Examiners of Marriage and Family Therapists
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 child's mental health records in the event of my death or incapacity, or the termination of my therapy practice is to contact Don Zablosky, MA, LPC-S, LMFT-S. Don Zablosky, MA, LPC-S, LMFT-S will have access to your child's records and can release them according to LPC and LMFT confidentiality ethical rules and 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

Risks of Therapy:

I understand that therapy services may involve discussing relationship, psychological, behavioral and/or emotional issues that may at times be distressing for my child. However, I also understand that this process is intended to help my child personally and with relationships. The success of the work my child does with the therapist depends on the quality of my and my child's efforts and the therapist's efforts, and the realization that I am and my child are 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 child's initial session will involve an evaluation of their needs and, depending on the 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 have your child enter therapy. You should evaluate this information along with your own opinions of whether you feel comfortable with your child working with the therapist. If at any point, you would like a second opinion, the therapist will be happy to help you and your child meet with another mental health professional.

Relationship:

Your child's 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 or your child. The therapist cares about helping your child, but is not in a position to be your or your child's friend or to have a social or personal relationship with your child. Gifts, bartering, attending personal events and trading services are not appropriate and should not be shared between you/your child and the therapist.

Minor Clients:

As the parent or guardian requesting services for your child under the age of 18, the therapist needs your permission to provide therapy services to him/her. Keep in mind, while you have the right to question and understand the nature of your child's sessions, treatment is usually more effective if your child has some privacy. It is therapeutically important that your child develops a level of trust with the therapist, so if you agree, the therapist will only provide you with a general overview of each session along with your child's level of participation and progress. However, there are limits to confidentiality (listed under "Confidentiality").

Goals, Purpose and Techniques of Therapy:

There may be alternative ways to effectively treat the problems your child is experiencing. It is important for you to discuss any questions you or your child may have regarding the treatment recommended by the therapist and to have input into setting the goals of therapy. As therapy progresses these may change. The therapist, in conjunction with you and/or your child, will examine the issue you and your child 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 your child will be better able to move toward resolving difficulties your child is facing:

Play therapy - In play therapy a therapist supports a child in using play to help them express their feelings and thoughts more easily through toys instead of words.

EMDR (Eye Movement Desensitization and Reprocessing) - a psychotherapy that utilizes eye movements or bilateral stimulation to support the brain's information processing system's natural movement toward healing from traumatic events.

Narrative therapy - the therapist seeks to help an individual or family co-author a new empowered narrative about themselves based on their values, strengths, and abilities by investigating their history. This new narrative may help to reduce or eliminate problems.

Cognitive Behavioral Therapy - this treatment focuses on helping to change thoughts in an effort to change behaviors and one's emotional state.

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

Confidentiality:

I understand that what my child discusses in therapy will generally remain confidential unless I give written permission to share information from my child's 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 (See Limitation on Confidentiality when Providing Therapy to Couples or Families).

However, the therapist may share information about my child's therapy with fellow licensed therapists for consultation purposes in the interests of providing quality care. The 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 your child is required to be in therapy or be evaluated by a court order
8. If your child claims harm to their 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, I am giving consent to the therapist to share confidential information concerning my child's treatment with all persons mandated or permitted by law, with the agency that referred my child, and the managed care and/or insurance carrier responsible for providing my child's mental health care services and payment for those services, and I am also releasing and holding harmless the undersigned therapist for any departure from my child's right of confidentiality that may result.

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Duty to Warn:

In the event that the therapist reasonably believes that your child is a danger, physically or emotionally, to themselves 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 your child or another person, in addition to medical and law enforcement personnel, and the following persons:

Name Telephone Number

_____

_____

Art Work:

_____ (initial) I give permission for my child's artwork to be viewed by others for education, training, research and/or consultation. I understand that my child's name will not be displayed on his/her artwork.

Records:

Records of any services your child receives are maintained in paper files locked within filing cabinets behind a locked door and/or in a secure password protected computer database. This database has the following features to support the confidentiality of your child's 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 your child's date of majority.

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 child's treatment or therapy sessions.
- Any therapy related questions or issues will be dealt with during the next therapy session.
- Emails or texts received from you and any responses sent will become part of your child's 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 or my child's mailing address, telephone number or email address.

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

The 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 the 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.

If your child has insurance and the therapist is an in-network provider, the therapist will file with your child's insurance company as a courtesy.

If the therapist is a provider in your child's insurance network the fee is reduced based on the amount the therapist contracted with your child's insurance company. In such cases, your child's insurance company will pay a portion of the cost of your child's therapy per session and the remainder (co-pay) will be due and collected at the time of service. If your child's payment is to be applied to the deductible, cost per session will be the amount the therapist has contracted with the insurance company.

Agreed upon payment is due at the time of service. Your child's insurance company will be billed for the services; however, you are ultimately responsible for the full payment of session fees.

In addition to weekly appointments, there will be charge of $120 hourly for other professional services your child may need. This fee will be prorated if work you request is less than one hour. Other professional services include:

- report or letter writing to teachers, physicians, psychiatrists, etc.
- site visits
- travel time to meetings, etc.
- telephone calls lasting longer than 15 minutes
- attendance at meetings or phone consultations with other professionals (that you have authorized)
- preparation of records or treatment summaries

None of these services are covered by insurance plans.

If your child becomes involved in legal proceedings that require the therapist participation, you will be expected to pay for all of the professional time, including preparation and transportation costs. Due to the complexity and difficulty of legal involvement, the fee is $170 per hour.

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

Emergency Situations:

Please note the 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 my child experiences a mental health crisis, I have been informed that I should contact one of the following: Adapt Mobile Crisis Line 866-260-8000 or Suicide Prevention Line 800-273-8255.

Consent for Treatment:

I hereby, voluntarily, consent to have the child in my legal custody 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. **If a custody agreement exist for my child, I will provide the therapist with a copy of the most recent custody agreement.**

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

I agree that the child indicated below will participate in ____ **individual therapy** ____ **family therapy** (check one). Within individual therapy the child is the treatment unit. In family therapy the entire family is the treatment unit. I acknowledge that the therapist's focus for therapeutic support is the treatment unit which is considered the client. The therapist will provide services to and be responsible for care of the indicated treatment unit. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

By signing this Client Information and Consent form, I, the undersigned parent/guardian, acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains.

Client Name: _____ Date of Birth: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

As witnessed by:

_____ Date: _____

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

Therapist