Susan Wade, LCSW
Certified Gottman Therapist

Client Information and Consent

This document contains important information about the professional services you will receive. Please read it carefully and write down any questions you might have so that we can discuss. When you sign this document, it will represent an agreement between Susan Wade, LCSW and yourself.

Therapeutic Relationship

It is imperative that your relationship with me remain solely therapeutic. Personal and business relationships undermine the effectiveness of the therapeutic relationship. Gifts, bartering, trading services and contact outside of the office, including contact through social media, are not appropriate.

Susan Wade, LCSW is not in a partnership with the office of Holly McFarland, LCSW JD or Scott Lennox, LCSW. While I am a Certified Gottman Therapist, The Gottman Institute and its agents have no responsibility for the services you receive.

Emergency Procedures

I do not provide 24 hour crisis counseling. In the event of an emergency, do not contact me. Call **911** or go to your nearest hospital emergency room.

Appointment Scheduling & Contact Information

Appointments may be scheduled 3 ways:
1. You may schedule an appointment online at SusanWadeFortWorth.com
2. You may call the office (817) 207 0042.
3. You may send an email to info@SusanWadeFortWorth.com

I am rarely available by telephone. If unavailable, please leave a message on my confidential voice mail. You may email for scheduling purposes or logistical questions only. Do not use email or voicemail to discuss or process therapy-related concerns. Please do not contact me via social media.

Confidentiality

Discussions between a therapist and a client are confidential. My utmost concern is to guard your privacy.

There are some rare exceptions, whereby I am required by law to report:
1. If you are planning on taking your own life;
2. If I determine that you are a danger to someone else;
3. If you disclose abuse, neglect, or exploitation of a child, elderly or disabled person;
4. If you have knowledge of abuse or neglect taking place in a mental health or rehabilitative facility;
5. If you are a minor - your parents have a right to your medical records;
6. If your records are subpoenaed in connection with a legal proceeding;
7. If you are in therapy along with someone else, these notes are the property of both parties, and can be obtained by any party involved;
8. If required by the secretary of the Department of Health for investigating compliance with the HIPAA Privacy Rule.

Additionally, in couples therapy, I cannot be asked to keep secrets between you and your partner.
Recording of sessions without the explicit written consent of all parties is strictly prohibited.

Fees & Payment for Services

Therapy payments are due at the time services are rendered. Payment for fees other than routine scheduled therapy sessions are due prior to services being rendered. I accept the following methods of payment: Cash; check; Visa; MasterCard and Discover; HSA and FSA cards and PayPal.

Fees

Couple's Diagnostic Interview (55 minutes)	$150
Couple's Counseling (55 minutes)	$150
Individual Counseling (55 minutes)	$150
Extended Couple's Session (2 hour)	$280
Extended Couple's Session (3 hour)	$400
Extended Couple's Session 1/2 day (4 hours)	$525
Extended Couple's Session 1/2 day (4 hours weekend)	$600
Same Day Cancelation/No Show fees	$100
Legal Appearances, Preparation, Testimony (per hour)	$300 (4 hour minimum)
Telephone Consultations (more than 15 minutes)	Prorated at individual session rate

In the event that disclosure of your records or testimony is required by law, the undersigned will be responsible for all costs involved whether services were requested by you or someone else.

Insurance reimbursements: Please note that I do not accept any insurance. However, upon request, I can provide documentation for out-of-network-services. It is your responsibility to verify the specifics of your coverage and to submit necessary documentation to your insurance company.

Therapist's Incapacity or Death

In the event I become incapacitated or die, it will become necessary for another therapist to take possession of my records. By signing this information and consent form, you give consent to allow another licensed mental health professional, selected by me, to take possession of your file and records and provide you with copies upon request, or deliver them to a therapist of your choice.

Risks of Counseling

"Therapy" is the Greek word for "change". Often growth cannot occur until one experiences and confronts issues that induce feelings of sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of the efforts given and the realization that one is responsible for lifestyle choices and changes that may result from therapy. Specifically, one risk of couples therapy is the possibility of exercising an option of dissolution.

Complaints and Grievances

I encourage you to discuss any problems you have with me directly. I am willing to work with you to resolve identified problems so that you can accomplish your therapeutic goals. If you are unable to resolve problems with me directly, you may contact my licensing board: Texas State Board of Social Work Examiners, PO Box 141369, Austin, Texas 78714-6718.

Cancelations

If for any reason you are unable to keep an appointment, it is essential for you to notify me 24 hours in advance of your scheduled appointment. You may notify me via voicemail, email or text. APPOINTMENTS NOT CANCELED AT LEAST 24 HOURS IN ADVANCE WILL BE CHARGED $100 FOR THE MISSED APPOINTMENT. By initialing below you acknowledge that you understand you will be charged for appointments canceled without 24 hours advanced notice.

Client 1 Initial _____ Client 2 Initial_____

Medical Records

Mental Health Practitioners are required by law to provide you with written notice about how mental health and medical information may be used, disclosed and how you can gain access to this information. The Notice of Privacy Practices is provided on my website SusanWadeFortWorth.com and offered to you at your first appointment. Please read this notice carefully and ask any questions you may have. By initialing below you are acknowledging receipt of this notice.

Client 1 Initial _____ Client 2 Initial_____

Consent to Treatment

The undersigned client, voluntarily agrees to receive mental health assessment, care, treatment and/or testing services, and authorizes Susan Wade, LCSW to provide such care treatment, and/or testing services as are considered necessary and advisable.

The number of sessions necessary to meet therapeutic goals is variable and depends on many factors to be discussed. The undersigned client understands and agrees that he/she will participate in the planning of care, treatment and/or testing services and that he/she may stop such treatment at any time. It is also understood that premature termination may result in failure to achieve therapeutic goals.

By signing this Client Information and Consent form, the undersigned client acknowledges that he/she has both read and understood all the terms and information contained herein. Ample opportunity has been offered to ask questions and seek clarification of anything unclear in this document, or otherwise, prior to treatment initiation.

Client _____Date_____

Client _____Date_____

Therapist _____Date_____