

The G.A.T.E.
Jonathan F. Anderson, MA, LPC, LPC-Supervisor
Professional Consulting, Psychotherapy & Supervision
(512) 771-7621
3355 Bee Caves Rd, #505
Austin, Texas 78746

Statement of Informed Consent

By entering into counseling you have certain rights, and other information of which you should be aware. Please review this document carefully, and let me know if you have any questions about its contents.

Right to Confidentiality (limits of confidentiality)

All information discussed in sessions will be completely confidential, unless specified in writing on the Consent for the Release of Information form. There are three (3) other conditions under which Federal Law requires counselors to breach confidentiality. These are:

1. Situations involving child or elder abuse
2. Situations involving abuse or exploitation of the disabled
3. Situations in which a person's life is in immediate danger

Right to appropriate referrals

You have the right to request referrals to other Mental Health professionals at any time. I am obligated to provide these referrals when:

1. Either you or I determine, either individually or collaboratively, that my services are not meeting your needs for any reason
2. When your needs are outside of my training level
3. When you request them for any reason

Right to terminate therapy

While I strive to partner with all of my clients to live happy, productive lives, I do understand that there may be circumstances when one may need to terminate therapy. In most circumstances, we will be able to determine together when therapy is complete, and thus plan a smooth transition. However, should you decide at any point to terminate therapy, you may do so.

Counseling purposes, goals and techniques

The purpose of counseling is to help you to lead a more happy and productive life. To this end, we will partner together to find solutions to issues you present. We will discuss various goals, and action plans to follow in pursuing them. This will often involve discussions of your thoughts, emotions, history and present perspectives.

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Potential risks of counseling

As we will likely be discussing sensitive issues, counseling may put you in a position to experience some uncomfortable emotions. We will partner together to help you cope with these feelings. Through your counseling, you may also find yourself faced with difficult, possibly painful decisions about your life. Again, we will strive to partner with you to make these decisions; however, the final decision of action (or lack thereof) lies with you.

Fees

Individual therapy sessions are \$150 per 45-minute session, \$250 per Individual 90-minute double-session. Group Counseling is typically \$50 per 80 minute session. The client may elect to use health insurance to get reimbursement for sessions, but Mr. Anderson does not submit claims for the client (except when Value Options is the Mental Health Insurance or EAP provider). The client is responsible for payment at the time of service, and may then submit bills to his or her insurance provider.

Cancellation Policy

For appointments not kept, canceled, or rescheduled within 24 hours of appointment for any reason, you will be responsible for your full session fee. Should I need to cancel your sessions for any reason, you will not be charged. If already paid for a session cancelled by me, you will be immediately refunded that session fee, or that fee may be applied to the next session.

My Travel obligations as a National Crisis Counselor

I sometimes travel as a Crisis Counselor to support during major disasters and crisis situations nationwide. Should I be called out when we have a session, I will call you to offer to reschedule our session. Please call if you have any questions, and thank you in advance for understanding.

Reporting Ethical Concerns

Should you need to report any Licensed Professional Counselor to their licensing board for ethical violations, please contact:

**Texas State Board of Examiners of Professional Counselors
1100 West 49th Street
Austin, Texas 78756-3183
512-834-6658**

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THERAPY AGREEMENT (please initial, then sign below)

** Phone consultations over 2 minutes will be billed at the rate of \$2.00 per minute for the full duration of the call. _____*

*** I agree to allow Jonathan F. Anderson, MA, LPC to communicate with my Primary Care Physician as appropriate and required by most insurance carriers to coordinate care. _____*

Doctor Name: _____

Phone Number: _____

~ To refuse authorization for contact with your PCP, initial here _____.

By signing below, I agree that I have read and understand the above information and rights.

Client Signature

Date

**Please return the original of this page, signed and dated, to the address below.
*Please retain a copy of this document for your records!!***

Thank you,
Jonathan F. Anderson, MA, LPC
Owner/Counselor, The GATE