Kara Smith, LCSW
EMDR & Psychotherapy

2990 Richmond Ave
Suite 630
Houston, TX 77098

281-410-1593 (phone/text)
karasmithlcsw@gmail.com
713-583-8838 (secure fax)

THERAPY AGREEMENT AND CONSENT TO SERVICES

The following is an agreement between **Kara Smith, LCSW** and ______________________ (**client name).**

The modalities of outpatient psychotherapy utilized in this office are widely accepted forms of psychological treatment. As with all forms of clinical treatment however, there are risks to be considered in the process of making an informed decision. This form is designed to inform you of these risks as well as the potential benefits of outpatient therapy, and to discuss the general policies and procedures of our office.

Overview of Clinical Services

Kara Smith, LCSW provides Individual and Couples Psychotherapy. Treatment approaches are based upon each client's specific clinical needs as identified during the initial session(s). Options are discussed and a treatment plan is determined. As your needs change, we will reevaluate the treatment plan. When this occurs, treatment options are once again discussed and determined by the client and therapist. If at any time the client and/or therapist believe the client's clinical issues require alternative or additional resources, every effort will be made to assist the client in locating these resources.

________ (initial) I am aware that I may end my treatment with this therapist at any time, and the only tasks I (the client), will be responsible for are notifying this therapist within 24 hours and paying for the services already received. I understand that if I stop my treatment with this therapist, they will ask that I speak with them about my reasons for doing so. I understand that this therapist may suggest continued treatment with a different provider if they assess that continued treatment is recommended. I also understand that I can ask my therapist for a referral should I wish to seek therapy elsewhere.

Benefits and Risks of Treatment

The benefits of outpatient psychotherapy may include improved functioning in your personal and professional relationships, improved communication skills and a reduction in the symptoms that led you to seek therapy in the first place. The risks or potential side effects of participating in psychotherapy may, at times, include increased levels of stress and anxiety, escalation of undesired behaviors, relationship disruption, and emotional reactivity.

Office Policies

1. Kara Smith, LCSW keeps and stores records for each client in a record-keeping system produced and maintained by TheraNest, LLC. This system is "cloud-based," meaning the records are stored on servers which are connected to the internet. TheraNest, LLC employs various technical security measures to maintain the protection of these records from unauthorized use or disclosure.

   o TheraNest, LLC is HIPAA compliant. All data is stored securely using Amazon Web Services. Amazon's servers infrastructure are certified, ensure the highest physical security and guarantee a 99.9% uptime. You can read more at https://aws.amazon.com/compliance. Amazon Web Services are also, HIPAA, and SOC compliant. AWS has achieved ISO 27001 certification and is a Level 1 service provider under the PCI DSS standards.

Kara Smith, LCSW has entered into a HIPAA Business Associate Agreement with TheraNest, LLC. Because of this agreement, TheraNest, LLC is obligated by federal law to protect these records from unauthorized use or disclosure.

2. **Payment** is due at the beginning of the time of service. Most insurance plans require a diagnosis as part of filing a claim for psychotherapy services. This diagnosis will be discussed with the client prior to providing a statement.

3. **Cancellation** of an appointment for therapy sessions require 24-hour advanced notice. Please contact Kara Smith, LCSW by phone or text at 281-410-1593 or by email at karasmithlcsw@gmail.com. Otherwise, you will be charged for the missed session. Additional information specific to fees and payment is further delineated in the Fee Agreement Form that has been provided and signed by you (the client).

4. **Fees** for psychotherapy are based on the rates established at the time of service and/or at the time of renegotiation. Other options for payment of services may be available and can be discussed on an individual basis. Additional information specific to fees and payment is further delineated in the Fee Agreement Form that has been provided and signed by you (the client).

5. **<u>If you are unable to reach your therapist and cannot wait for them to return your call, contact 911 or go to the nearest emergency room.</u>**

2990 Richmond Ave
Suite 630
Houston, TX 77098

281-410-1593 (phone/text)
karasmithlcsw@gmail.com
713-583-8838 (secure fax)

Please note: Text messages are not a secure means of communication with regards to privacy and confidentiality.

Confidentiality

Information shared with a therapist is held in confidence. A signed and dated Release of Information (which clearly defines the nature of information to be shared, to whom and for how long) is required as consent to disclose confidential information.

Limitations to Confidentiality

The law protects the relationship between a client and a psychotherapist, and information cannot be disclosed without written permission. However, there are exceptions. These exceptions include:

1. Suspected child abuse or dependent adult or elder abuse, for which the therapist is required by law to report this to the appropriate authorities immediately.

2. If a client is threatening serious bodily harm to another person/s, the therapist is required by law to report this to the appropriate authorities immediately.

3. If a client intends to harm himself or herself, the therapist will make every effort to enlist your cooperation in ensuring your safety. If you do not cooperate, the therapist will take further measures without your permission that are provided to the therapist by law in order to ensure your safety.

Complaints

Complaints against this therapist can be made by contacting:

The Texas State Board of Social Worker Examiners
1100 West 49th Street
Austin, Texas 78756-3183
(800) 232-3162 or (512) 719-3521

By signing this document I acknowledge informed consent in my decision to seek outpatient psychotherapy with this therapist and I have had an opportunity to ask questions. I also acknowledge that my signature below means that I understand and agree with all of the points above.

Client Name | Client Signature | Date

I, the therapist, have discussed the issues above with the client. My observations of this client's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Kara Smith, LCSW

Therapist Name, Credentials | Therapist Signature | Date

□ Copy accepted by client □ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure and/or transfer are expressly prohibited by law.