CONSENT for TREATMENT

I, ________________________________, give my consent for treatment by Michael Ellison, Ph.D., LPC-S. I acknowledged and understand that some risks may be associated with treatment, and that those risks have been explained to me. Dr. Ellison may discuss all information regarding my treatment with qualified mental health professions for consultation purposes. Fu1thermore, I agree and understand that all confidential information may be disclosed in the case that my records are subpoenaed in court. I understand and agree that confidentiality and privacy will not be upheld in the case that Dr. Ellison believes me to be a danger to myself, or others. I give Dr. Ellison full permission to warn others of my intent to harm them in any way.

Finally, I understand that confidentiality cannot be guaranteed by others in a group setting, but I agree to respect the privacy of other participants and will not disclose information outside of group. Other information that will not be held confidential includes suspected abuse or neglect of a child or elder person. In addition, if I inform my counselor of a communicable disease, my counselor may be required to report to the Texas Department of Health. I authorize my counselor to share information with another party if I give written consent.

I understand and consent to the following as well:

- In an emergency, if I am unable to reach my counselor, I will call 911 or go to the nearest hospital
- I must provide advance notice of two business days if I must reschedule or cancel a session.
  I **will be billed for the entire hour if** I **do not provide such notice. Please initial:** ____________
- The initial session (diagnostic) fee is $150.00.
- The fee for each 50-minute session is $120.00, with cash payment due at the time of service unless prior arrangements have been made. I understand that if I default on payment, legal action may result, or I may be reported to a collection agency.
- In the event that Dr. Ellison must appear in court, I agree to pay $350.000 per hour including travel time both ways, with a minimum of four hours reserved ($1,400). Additional hours for preparation will be charged at the rate of $350.00 per hour. Fees for court appearances must be paid 10 working days in advance. If the court session is cancelled, for any reason, I forfeit any fees.
- I agree to pay a fee of $35.00 for each check returned for insufficient funds.
- In the event of the death or disability of Dr. Ellison, my records and case will be referred to Susan Dalrymple, LCSW, MPA.
- I understand that Dr. Ellison is not responsible for insurance claims or any other third-party reimbursement.

Client Signature: ______________________________________ Date: ________________

Parent or Guardian: ____________________________________ Date: ________________

Michael Ellison, Ph.D., LPC-S
(817) 269-5578

CLIENT HISTORY

Name ____

Date of Birth _________________________ Age ___________

Address _________________________________

____

Marital status ____________________________

Home Phone ( )___________________ Cell phone ( ) _________________________

Employer ____

Work Phone ( ) ____________________ May I call you at work? ___Yes ___ No

Emergency Contact:
Name____

Phone ( ) ____

Please list the name of your Primary Health Care Provider ________________________

Have you had prior mental health/chemical dependency treatment? ____Yes ____ No

If so, when? ___________ Where ?____

Are you receiving mental health/chemical dependency treatment now?__Yes __No

If so, name of treatment provider_____________________Phone ( ) ___________________

Current medications ____

What problem(s) bring you into counseling now? _____________________________

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On a scale of 1 to 1O (with 1O being the worst), rate your problem severity ___________

Please let us know who referred you ______________________________________