

PERSONAL INFORMATION FORM – CHILDREN AND YOUTH

NAME : _____

ADDRESS : _____

MAILING ADDRESS (if different from above) : _____

EDUCATION:

Grade _____ School _____ Any Grade Level Retention? Y/N

PERSON RESPONSIBLE FOR PAYMENT: _____ Child DOB: _____

PERSON WHO REFERRED YOU TO ME: _____

May I send a note of thanks for the referral? () Yes () No

FAMILY OF ORIGIN ATMOSPHERE:

Father's Name _____ Age _____

Mother's Name _____ Age _____

Living () Deceased () Date _____

Living () Deceased () Date _____

Address _____

Address _____

Phone (H) _____ (W) _____

Phone (H) _____ (W) _____

(C) _____

(C) _____

Occupation _____

Occupation _____

Employer _____

Employer _____

Address _____

Address _____

Birthdate _____

Birthdate _____

Parents separated or divorced? No () Yes () Child's age at time of separation/divorce _____

Did you have step-parents? No () Yes () Your age at time of parent remarriage _____

List brothers and sisters from oldest to youngest (include child coming for therapy)(Circle step-siblings) _____

All living? Yes () No () If no, name(s) of deceased and date _____

Which of the siblings is the child most like? _____ How? _____

Which of the siblings is the child least like? _____ How? _____

Which of the siblings is the child in most conflict with? _____ Why? _____

Which sibling is more like Mom? _____ How? _____

Which sibling is more like Dad? _____ How? _____

Describe the relationship between you and your spouse. _____

Who makes the decisions? _____ Do you agree on child rearing methods? _____

Do you disagree openly? _____ About what? _____

Describe other environmental influences on the child. _____

Who has been important to the child (Grandparents, other relatives, friends or neighbors)? _____

In what way? _____

Do any of the family members use alcohol or other drugs? Yes () No () If so, to what extent? _____

Is this a family problem? Yes () No () If so, how do you cope? _____

Any other pertinent family history/information: _____

PERCEPTION OF THE CHILD:

How does the child stand out in the family? _____

What has he/she been successful at? _____

What does he/she get into trouble for? _____

What does the child want to be when he/she grows up? _____

What are the child's responsibilities (getting self up in the morning, to sleep at night, household chores, pets, etc)? _____

Does the child have nightmares or dreams? Yes () No () How often? _____

What are the dreams about? _____

Does your child:

Get feelings hurt easily? Yes () No ()	Have any friends? Yes () No ()	Athletic? Yes () No ()
Have a bad temper? Yes () No ()	Have high standards? Yes () No ()	Follow rules? Yes () No ()
Complain/find fault? Yes () No ()	Try to please others? Yes () No ()	Acts selfishly? Yes () No ()
Do nice things for others? Yes () No ()	Help around the house? Yes () No ()	Like to be alone () or with others ()

FUNCTIONING AT LIFE TASKS:

How does child get along with adults? _____

Favorite adult to be with? _____ Least favorite? _____

How does child get along with children in the neighborhood? _____

Does child prefer to play with other children of the same age, younger, or older? _____

How does child get along with peers at school? _____

Does child have a best friend? _____ Describe him/her: _____

Does the friend come over very often? _____

How do things go for him/her at school? _____

What does he/she get into trouble about at school? _____

What do you do about it? _____

Does child make good grades? Yes (☐) No (☐)

TRAUMA IN THE FAMILY:

What traumatic events have occurred during the child's life (divorce, death, abuse observed, etc.)? _____

BEHAVIORS:

If any, what are some of the behaviors that the child engages in that are annoying to you or to other family members? _____

What do you do in response to these annoying behaviors? _____

How do you feel if these annoying behaviors persist? _____

What does the child do in response to discipline? _____

RELIGION: _____

Religion is: Satisfying (☐) Challenging (☐) Dull (☐) Meaningless (☐) Irrelevant (☐)

HEALTH:

General Condition: Excellent (☐) Good (☐) Fair (☐) Poor (☐) Date of last physical _____

Physical Disabilities or Limitations: _____

Current Medications and Dosage: _____

Injury/Illness/Allergies: _____

Has child ever contemplated or attempted suicide? Yes (☐) No (☐) If yes, when? _____

Has child ever contemplated or intentionally harmed another person? Yes (☐) No (☐) If yes, when? _____

Sleep Pattern: Normal (☐) Restless/Broken (☐) Insomnia (☐) Oversleep/Hard to Wake (☐) Nightmares (☐)

Therapist: _____

Substance Use? (Alcohol, Tobacco, Illicit Drugs) Yes () No () If yes, what, when, and/or how often? _____

PREVIOUS COUNSELING OR PSYCHOTHERAPY? Yes () No () If yes, when? _____

Received from: _____ Phone: _____

PLEASE RATE CHILD'S OVERALL HAPPINESS 1-5 (1=AWFUL; 5=GREAT): _____

DREAMS FOR THE CHILD:

What are your hopes for the child? _____

Is there anything else that I should know about him/her? _____

PLEASE HAVE CHILD COMPLETE THE FOLLOWING SENTENCES:

Some of my strength are...

Fun for me is...

I came here today...

Six months from now...

I testify to the best of my knowledge, the information provided above is accurate and complete. I further grant permission for a Tranquil Hearts Counseling Center therapist to consult and share, should she deem it necessary, pertinent information concerning me (my child) with other professionals in order to aid my counseling/growth process.

Client/Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly with appropriate authorization to share information.
- Obtain payment from third-party payers, if applicable.
- Conduct normal healthcare operations such as quality assessments and record keeping.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

Date:	Initials:	Reason:
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INFORMED CONSENT – PRIVACY POLICY – THERAPY AGREEMENT

Welcome! This document answers many questions clients often ask about therapy and explains procedures, expectations, and privacy policy. After reading and fully understanding its contents, you will be asked to initial each page and sign the agreement. Please retain a copy for your records/reference.

SESSION FEES:

Intake: **\$195**

Couple/Family: **\$250**

Individual/Child: **\$175**

Court Related Services: If I am required to participate in legal proceedings related to your care, you will be responsible for all associated costs. Fees need to be paid for court appearances 48 hrs. in advance. These rates reflect time, preparation, and professional responsibilities required for court involvement. I am not an expert witness, and per Texas Family Code I am unable to make decisions pertaining to child custody.

- Court appearances: Minimum charge of \$1600, which includes up to 7.5 hours of time. Additional time is billed at \$250 per hour.
- Depositions/Testimony/Court filings and document preparation: \$250 per hour
- Letters, Summaries, and Records: Clients may occasionally request written documentation for personal, school, or agency purposes.

Fees are as follows:

- ESA Letters (for animals not qualified as aggressive breeds by the State of Texas): \$125
- Letters for schools/agencies: \$125 (plus postage, if mailed)
- Treatment summaries: \$150 (plus postage, if mailed)
- Records Request: \$75 plus \$1.00 per page

Services such as phone calls lasting longer than 15 minutes, consultations with other providers, preparation of treatment summaries, or participation in school/agency meetings will be billed to the client at \$150 per hour, prorated in 15-minute increments.

All professional time will be billed for at a rate of \$2 per minute. This includes writing or reading reports or letters on your behalf, scoring of rating scales/evaluations, consultation/phone calls, email communication, extended sessions, copying/mailing of records, off-site observations (including travel time), etc. While there is no charge for calls to schedule/change appointments, inquire about services, etc., after hours consultation calls are charged 150% of the usual rate.

Your session time is for you and is taken seriously. *You are contracting for the time you have scheduled.* Please make every attempt to attend your scheduled sessions and arrive on time. **Twenty-four (24) hour notice is required in order to cancel an appointment.** To maintain consistency from one client to another and to maintain flexibility to be able to meet with clients in a timely manner, *exceptions (excluding unavoidable emergencies) will not be made.* If an appointment is not canceled 24 hours in advance, **you will be charged for the session.** This helps to eliminate “No Shows” and ensures maximum appointment availability for you.

PAYMENT:

Payment in full for all professional services is due at the time of the service. You (or parent/guardian) are directly responsible for payment. Fees may be adjusted individually, based on the needs of the client when agreed upon by the provider. **Checks should be made payable to your individual therapist. Credit cards and cash are also accepted, along with Venmo and Zelle.** It is helpful to have checks made out before the session begins. **Returned checks are subject to a \$35 service fee which must be paid prior to the next appointment, and future payments will be required to be made with cash or money order.** Because payment is due when services are rendered, we usually do not send bills. If, however, a situation necessitates that you be billed, please remit payment within five days of receiving the invoice. Should payment problems arise, they must be worked out openly and quickly. Such problems can greatly interfere with counseling/therapy progress and our working relationship.

Insurance: Your health insurance policy is a contract between you and your insurance company. We do not contract with insurance companies to be one of their network providers and are not a party to your specific contract. You may be eligible for “out of network” benefits, but will need to research the extent of your coverage to make this determination. Insurance benefits may only apply to the counseling/therapy services which we provide as a Licensed Professional Counselor. You are responsible for completing and filing

the necessary paperwork for insurance reimbursement. We will provide you a receipt for services rendered. Please let us know if you intend to access your insurance benefits as additional information, such as a specific diagnosis, if determined to be present, is usually required. You are also responsible for keeping track of your benefit requirements/limitations such as the number of sessions allowed per calendar year, authorized time periods, and so on. Please be aware we have no control or responsibility for confidentiality procedures employed by your insurance company. Should you choose insurance as an option, we may be required to provide the company with your personal health information, which includes history as well as current status, for you to be reimbursed. You must give written permission for the release of your personal health information.

CONFIDENTIALITY:

All information shared in session is held in strictest confidence according to federal regulations. The following are exceptions: 1) Legal obligation such as child or elder abuse, court subpoena, cooperating with law enforcement officers, etc., 2) Suspected personal danger to yourself or an identifiable victim, 3) Information required by insurance companies for payment (for which you consented), 4) Information provided to parents if the client is a minor, 5) Valid collection of a debt, and/or 6) Consultation with other professionals in order to aid in the counseling/therapy process (identifying information will be withheld unless written permission is given). Release of information to other individuals, agencies, or professionals may only be done with your written consent.

OFFICE HOURS/APPOINTMENTS:

Contact your individual therapist for office days and times. You may ask to have the same time each week for your appointment. We will do our best to accommodate your request, as certain time slots are in demand and fill quickly.

When in session with a client, we will not be able to take phone calls. Please leave a message on our individual voicemail. We make every attempt to return calls daily. Emergency calls may be taken after hours and charged the 'after hours' rate. As we honor and value our personal self-care time and time with family, we ask that you limit after hour calls to emergencies only.

TELEPHONE ACCESSIBILITY POLICY:

If you need to contact me between sessions, please leave a voicemail message. When in session with a client, we will not be able to take phone calls. Since a typical session is 50 minutes in length, we use the remaining 10 minutes of the hour to return phone calls, complete paperwork, and address any self-care needs. We make every attempt to return calls daily. Emergency calls may be taken after hours and charged the 'after hours' rate. As we honor and value our personal self-care time and time with family, we ask that you limit after hour calls to emergencies only. In addition, my voicemail cannot be used as an emergency service. If I am not immediately available, I will attempt to return your call within 24-48 hours. If a true emergency arises, please call 911 or any local emergency room. I return text messages between the hours of 8am-8pm Monday-Friday. Please note, if you text me, please do not assume I have received it and text me again or give me a call if you have not heard back from me within 24 hours.

EMERGENCIES:

As a rule, our practice is not crisis oriented in nature. If you feel you will need more intensive after hours support on a regular basis, please inform us during our first session. We will be happy to help you locate a provider whose practice is more suited to on-going crisis intervention.

For an emergency, please attempt to contact your individual therapist. If we cannot be reached immediately by phone, you, your family member, or friend should call the **HOUSTON CRISIS HOTLINE at 713-468-5463, DIAL 911, or GO/BE TAKEN TO THE NEAREST HOSPITAL EMERGENCY ROOM.**

THERAPIST INCAPACITATION/DEATH: In the event of my death, serious illness, or incapacity, I have designated Jessica Jensen, LPC, to manage client notification, records, and continuity of care. This individual may contact you regarding referrals, records requests, or other administrative matters related to your treatment. Client records will remain confidential and will only be accessed as permitted by law and professional ethics. You may request a copy of your records or referrals for continued treatment at that time. Jessica Jensen can be reached at 979-221-8749 or jensencounselingllc@gmail.com.

LEGAL MATTERS:

Should you ever become involved in a divorce or custody dispute, **we will not provide evaluation (written or otherwise) or expert testimony in court.** You should hire a different/neutral mental health professional for any evaluation or testimony you require. This position is based on two main reasons: 1) Our statements will be seen as biased in your favor because we have a counseling/therapy

relationship, and 2) the testimony may affect the counseling/therapy relationship, and we must put this relationship first. This applies to all clients regardless of age.

If, as part of your session work, you create/provide to us records, notes, artworks, or any other documents or materials, we will return the originals to you at your written request but will retain copies. You have the right to review or get copies of your personal health information with limited exceptions. You must submit a written request and allow a reasonable time period (maximum of 30 days) for compliance. If you are concerned that we have violated your privacy rights, or disagree with a decision we have made in regards to access to your personal health information, please inform us immediately. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Violations: In our practice we follow the professional code of ethics of the American Counseling Association. Any violations of the Licensed Professional Counselor Act should be reported to: Texas State Board of Examiners of Professional Counselors, 1100 West 49th Street, Austin, TX 78756-3183, 512-834-6658.

ABOUT THERAPY:

Seeking help through counseling/therapy is a wonderful way to gain new clarity as well as obtain practical tools to support you in your daily living and in navigating life transitions. Because you will be investing time, energy, and money, it is important to choose a therapist with whom you are comfortable.

Our work together will focus on wellness and increasing overall life satisfaction. Utilizing a problem-solving/skill-building approach, we will work together to identify developmental and/or life issues and concerns with which you may be dealing *and* useful skills to help you address your problems. We will devise a plan to help you incorporate your new skills into your daily living. Homework may be assigned which you will be asked to complete as a means of moving toward the achievement of your goals.

Although no counselor/therapist can ethically guarantee achievement of goals, it has been our experience that the more you put into the process, the better the chance for positive, lasting results. Because the work that we do *is* a process and often has a cumulative effect, *it can be helpful to commit to a minimum number of at least six sessions.*

While you most likely will experience gains in as little as one session, it generally takes longer for deeper work. You or your therapist have the right to terminate this agreement at any time. At least one session's notice is helpful for all involved, should the decision to terminate, by you or by the therapist, occur. This allows for closure. If needed, you will be provided the names and phone numbers of other qualified counselors/therapists.

The Benefits and Risks of Counseling/Therapy: There may be some risks as well as many benefits with counseling/therapy. You should think about both the benefits and risks when making any treatment decisions. For example, there is a risk that you will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other such feelings. You may recall unpleasant memories which may bother you in settings outside of our sessions. You may receive feedback from some people who mistakenly suggest participating in this process is a sign of weakness. (By the way, we believe investing in your personal growth is a sign of courage and strength!)

Also, this process has the potential to impact your relationships with people who are important to you such as members of your family. You may experience a temporary worsening of problems after beginning, although this usually passes as you learn new skills and increase your self-confidence in applying them. Most of these risks are to be expected when making important changes in your life. Finally, even with our best efforts, there is a risk that counseling/therapy may not work out well for you.

While you consider these risks, you should also know the benefits of counseling/therapy have been scientifically researched and validated. People who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. Through this work, you will have a chance to talk things out fully until your feelings are relieved or your problems are solved. Your relationships and coping skills may improve greatly, increasing your overall satisfaction. Your personal goals and values may become clearer. You may find yourself growing in many directions and experience an increased ability to live authentically and fully enjoy your life.

What to Expect from Our Relationship: Services are best provided in an atmosphere of trust. You expect us to be honest with you about your problems and progress, and we expect you to be honest with us about your expectations for services, your compliance with medical advice from your doctor, and any other treatment issues. As a Licensed Professional Counselor (LPC), we will use our best knowledge and skills to help you achieve your goals. Our duty is to care for you and my other clients, but *only* in the professional roles of counselor/therapist. Ethically, we are bound to avoid "dual relationships." We are not able to advise you from other

professional viewpoints such as law, medicine, finance, etc. We must honor confidentiality (excluding the areas mentioned below as confidentiality exceptions). To maintain privacy, we do not reveal the identities of our clients without their consent. Therefore, if we meet on the street, we may not say hello or talk to you very much. *This would not be a personal reaction to you, but rather an effort to maintain the confidentiality of our relationship.* Lastly, we cannot socialize or have a romantic relationship with any of our clients and cannot provide counseling/therapy to any family members or friends.

AGREEMENT:

I, _____, confirm that I have read, or have had read to me, in its entirety, this document. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the policies and procedures listed in this document. I understand that no specific promises have been made to me by the therapists at Tranquil Hearts Counseling Center, about the results of treatment, the effectiveness of the procedures used by them, or the number of sessions necessary for therapy to be effective. I understand that after therapy begins, I have the right to withdraw my consent at any time, for any reason. I will make every effort to discuss my concerns about my progress with my therapist before making the decision to end therapy.

I hereby agree to enter into a professional working relationship, as detailed above, with a Tranquil Hearts Counseling Center therapist, (or to have my minor child enter), and to cooperate fully and to the best of my ability, as shown by my signature here.

Signature of Client (Parent/Guardian)

Date

Having met and discussed with this client (and/or client's parent/guardian) the policies and procedures outlined in this document and having responded to all questions posed, we believe this person fully understands the information presented. We find no reason to believe this person is not fully competent and capable, legally or otherwise, to give informed consent. Therefore, we, Tranquil Hearts Counseling Center therapists, agree to enter into a professional working relationship, as detailed above, with this client as shown by our signature here.

Signature of Therapist

Date

Tranquil Hearts Counseling Center

16712 Huffmeister Rd, Building 400A
Cypress, TX 77429

Erin Silva (281)433-1363
Julie Casten (773)329-7556
Alison Lampton (832)630-0777
Jessica Jensen (832)229-4102
Lyla Payne (832)620-1680

PROPERTY DESTRUCTION/INAPPROPRIATE BEHAVIOR AGREEMENT

The therapists at Tranquil Hearts Counseling Center care about each person who enters our office and we strive to create a safe and comforting experience for everyone. In order for us to provide the finest tranquil environment possible while you and/or your loved one receives therapy, we ask that everyone is respectful of the people and property here.

Please understand that you are responsible for the cost of any property damaged while you are in our office, including toys in the waiting area, furniture, rugs, walls, etc. Included in this agreement is disruptive or offensive behavior of any kind which causes your therapy session or others to be interrupted for any reason.

By signing below, you indicate your acceptance of this agreement and understand that the minimum fee to be paid for destroyed property is \$30, but may increase at the owner's discretion based on the situation and the amount of the actual cost of damage. If your behavior or that of your loved one becomes offensive or disruptive, you will be asked to leave the office immediately.

PATIENT NAME

SIGNATURE OF RESPONSIBLE PARTY

DATE

Thank you for partnering with us to make our office a more peaceful place!

- Tranquil Hearts Counseling Center Therapists



Email and Text Message Communication Consent Form

Email and Text Communication:

By signing, I allow THCC staff to communicate with me about my health using electronic mail (e-mail) and/or text message (SMS) communication.

Important Points:

- E-mail and text messages are not private or "secure".
- E-mail and text messages can be altered or "forged".
- E-mail and text messages can be forwarded without your permission (either on purpose or by mistake). If forwarded, the information may no longer be protected by HIPAA privacy rules.
- Backup copies of e-mail or text messages may exist even after it has been deleted.
- E-mail and text messages may not be seen or answered right away. Please call for urgent issues.
- A copy of all e-mail and text communication is added as a part of the medical record. E-mail and text messages can be used in court cases whether or not the information relates to your diagnosis and treatment.

Text Message Reminder Request:

- I request that THCC send text messages to a mobile device of my choosing to remind me of the date and time of my scheduled appointments. I understand my wireless carrier may charge me for such messages.
- I understand I will need to complete a new Email and Text Message Communication Consent Form if I would like to be contacted at a different number or email address.
- I understand that THCC still requires at least 24 hours' notice for cancelation of therapy appointments to avoid fees.

Additional Information:

- You may withdraw or cancel this authorization at any time by sending written notification to your THCC therapist. Your withdrawal will not apply to e-mails or text messages sent before the written notice is received.

I (we) understand the information stated above and understand that e-mail and text messages are not a secure means of communication. I understand that the provider may decline to communicate via e-mail or text message depending on the nature of the information. I give permission for THCC to use electronic mail (e-mail) and text message as a means of communication regarding my (or my child's) care. I understand that I may withdraw this authorization at any time by notifying THCC in writing.

Client (or Parent) Email Address(es): _____

Client (or Parent) Cell Number(s): _____

Client Name (Printed)

Parent Name (Printed)

Client (Parent) Signature

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Pre-Authorization Charge Form

I authorize Tranquil Hearts Counseling Center to keep my signature on file and to charge my Credit Card listed below **for missed appointments and late cancellations.**

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Client's Name : _____

Cardholder's Name : _____

Choose Card Type : VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Account Number : _____

Expiration Date : _____

Card Verification No.: _____

Billing Zip Code : _____

Cardholder Signature: _____

Today's Date : _____

Erin Silva, M.Ed., LPC
Tranquil Hearts Counseling Center
16712 Huffmeister Rd, Building 400A
Cypress, TX 77429
(281)433-1363

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize Erin Silva, M.Ed., LPC and

(Name of person(s) or organization(s) which disclosure is to be made to and/or received from)

(Address)

(Phone Number)

to disclose or release **one to the other** the following information from my records:

_____ All Health Care Information
Initials

_____ Health Care Information or Opinions Relating to any or all of the
Initials following treatment(s) and/or conditions:

_____ 1. Psychiatric or Mental Health Information
Initials

_____ 2. Academic and Confidential School Information
Initials

_____ 3. Testing
Initials

_____ 4. Other _____
Initials

For the purpose of treatment/management and/or supervision or psychological and/or medical conditions(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

PATIENT

DATE

PARENT OR LEGAL GUARDIAN

DATE



Teletherapy Informed Consent Form

I, _____, hereby consent to engage in teletherapy with _____ . I understand that "teletherapy" may include consultation, treatment, emails, or telephone conversations. I understand that teletherapy also involves the communication of my medical/mental health information both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Informed Consent – Privacy Policy Agreement which I received with this consent form.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and confidentiality cannot be guaranteed.
4. I understand that teletherapy-based services and care may not be as complete as face-to-face services, and if the therapist believes I would be better served by another form of therapeutic service (e.g.: face-to-face services) I will be referred to a professional who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that I may benefit from teletherapy, but the results cannot not be guaranteed or assured.
5. I accept that teletherapy does not provide emergency services. During our first session, the therapist and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts, or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour support.
6. I understand that I am responsible for providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions; the information security on my computer; and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions during my therapy sessions.

I have read, understand and agree to the information provided above.

Signature and Date

Client Printed Name



16712 Huffmeister Rd, Bldg 400A, Cypress, TX 77429; 281-433-1363

Erin Silva, M.Ed, LPC, ICST

Interactions with Therapy Dog: Informed Consent, Release and Waiver

INTRODUCTION:

Louie was born on August 16, 2019. He is a 24-pound white Cockapoo, which is a mixed breed between a Cocker Spaniel and a Poodle. I rescued him at three months of age, and Louie has received numerous behavioral training courses over the last three years. He loves people of all ages, to give hugs and play fetch. Louie can walk on his hind legs and shake. He is a very calm, sweet, and loving dog.

RISKS AND BENEFITS:

There are many benefits associated with working with therapy animals. Some benefits that have been found in utilizing therapy animals include:

- Animals help improve motivation and engagement in therapy.
- Animals provide a sense of security and emotional support. Dogs offer unconditional acceptance and positive regard.
- Animals can promote relaxation. Research has demonstrated that petting an animal can help lower blood pressure, heart rate, and increase oxytocin (a feel-good chemical in the brain).
- Animals can help the client learn frustration tolerance and other anger management techniques.
- Animals can help in the areas of focus and attention.
- Animals can be instruments of learning, which can increase self-confidence and self-esteem.
- Animals offer humor and fun due to their playful nature.
- Animals in therapy ask for clients to develop empathy, nurturance, and responsibility, and model other skills like forgiveness and patience.

Even though there are many benefits to working with therapy animals, there are risks involved in utilizing this method of therapy. For example: dogs may nibble, accidentally scratch, lick, lean up against a client, and/or cause light bruising. These actions are not aggression but rather the dog's way of interacting with the client. In addition, if the client is allergic to dogs or is unaware of an allergy, the client may suffer from an allergic reaction.

ASSESSMENT:

Working with a therapy dog in training may not be appropriate for each client or at every session.

Its use will be determined on a case-by-case basis. In the following circumstances, working with Louie will not be used or will cease:

1. If the client has a history of animal abuse/cruelty, or there are other risk factors that indicate potential harm to Louie.
2. If the client has a known allergy to dogs or an unknown allergy becomes known during therapy.
3. If the client exhibits problematic behavior toward Louie, including but not limited to: kicking, biting, pushing, hitting, pulling the tail/ears/paws, and/or pinching Louie.
4. If the client has a fear of animals and the scope of the client's therapy is not meant to address that fear.

ALLERGIES:

The client shall inform Erin of any and all known allergies. Louie may be at Erin's office every day. Although a specific client may not be interacting with Louie, he will still be present in Erin's office. If the client has an allergy to Louie, Erin will then determine whether any arrangements may be made to accommodate the allergy.

ACCIDENTAL INCIDENTS:

If Louie accidentally scratches, nibbles, or otherwise causes any harm to the client, the client agrees to notify Erin immediately.

INTERACTIONS WITH LOUIE:

Dogs interact with humans differently than when humans interact with each other. Dogs wag their tails, lick people, may lean up against a person's leg, or lay near a client. This is how Louie interacts with humans. If the client is uneasy or otherwise uncomfortable with how Louie interacts with him/her, client agrees to express those concerns immediately to Erin.

If a client prefers that Louie be in his crate during sessions, please let Erin know beforehand.

CONDUCT TOWARD LOUIE:

1. Just like a human being, Louie should be treated with respect and kindness. If Louie is sick or injured, he will not actively be working, however, therapy services will continue. Louie will obtain veterinary approval prior to resuming work if he is sick or injured.
2. Erin is also required to look out for the general welfare and safety of Louie. If at any time Louie becomes irritated, frightened, distressed, or in any way exhibits a negative and/or aggressive behavior,

he will take a break. If this occurs, only Erin may interact with Louie until in Erin's sole and absolute discretion he is able to return to the session.

DISEASE:

Every effort will be made to ensure against zoonotic disease transmission (i.e. the sharing of disease between humans and animals). Louie will remain current on all standard vaccinations, such as rabies; however, there is always a risk of the transmission of a disease when working with animals. A client may request to review a list of vaccinations for Louie.

RELEASE AND WAIVER:

I, _____ hereby agree for myself and/or my minor child to hold Erin Silva harmless from any and all claims and/or damages (including medical fees and attorney fees) and causes of action of any nature for any and all personal and/or bodily injury or illness, which may occur to myself or my minor child, or which may be aggravated or caused by the negligence of others while interacting with Louie.

ASSUMPTION OF RISK: I, _____ individually and/or on behalf of any minor child, specifically assume any and all known and unknown risk of injury or illness, resulting from interacting with Louie, which may include, but is not limited to: zoonotic disease transmission, scratching, nibbling, heavy leaning, jumping, light brushing, and/or licking by Erin, and any unknown or known allergic reaction.

I agree to abide by Erin's office policies and procedures as they specifically relate to Louie and his training as a therapy dog. If I have any questions as to conduct that is appropriate when interacting with Louie, I agree to ask Erin before engaging in such conduct.

If any injury and/or illness occurs while at Tranquil Hearts Counseling Center, I, individually and/or on behalf of my minor child, hereby authorize Erin to contact the medical professional listed below, or if the medical professional is unavailable or cannot be reached, to call 911 or the nearest hospital. I take full responsibility for my welfare and safety as well as for my minor child; and I hereby give permission for emergency medical treatment to be administered as deemed appropriate.

Name, Address and Phone number Information for Medical Professional:

I, individually, and/or on behalf of my minor child, being informed of the above known risks, and acknowledging other potential unknown risks, have read the above waiver and release. I understand that by signing this Agreement I, individually, and/or on behalf of my minor child am waiving certain legal rights.

Client's Printed Name

Client/Parent/Legal Guardian Signature

Date

Erin Silva, M.Ed, LPC, ICST

Date

