Barbara Buchanan, Ph.D., LMFT-Associate
Supervised by Dr. Corey Allan, LPC-S, LMFT-S
"Helping couples and families with today's life challenges."

PROFESSIONAL DISCLOSURE STATEMENT
Therapy Policies, Procedures and Services

Welcome! I am committed to providing you with quality care. This information packet is intended to acquaint you with what you can expect, and address some of the typical areas of concern, especially for the first-time client. We will also review the following consents verbally and I will answer any questions you may have regarding this document and/or therapeutic process. Your signature at the end of this document acknowledges and indicates that you have thoroughly read and understand this information, thus providing an agreement for proceeding with treatment.

Qualifications: I am a graduate from Texas Woman's University with a Doctoral degree in Marriage and Family Therapy and Texas Christian University with a Master's degree in Secondary Education. I am qualified as a licensed therapist to counsel per the Texas Department of Health guidelines. My formal education has prepared me to counsel individuals, families, couples and groups. I am a member of the American Association of Marriage and Family Therapists.

Experience: Throughout my formal education, internship and private practice each have offered me the opportunity to counsel many individuals, couples, families and groups of people. The most exciting about these experiences is that it also offered me the opportunity to work with diverse populations and a variety of life challenges. From newly engaged couples to those family members or couples experiencing crisis, I've taken additional trainings to meet your needs. I am a certified trainer for Prepare-Enrich Premarital course and Externship trained with Emotionally Focused Therapy by Dr. Sue Johnson the founder of The International Centre for Excellence in Emotionally Focused Therapy (ICEEFT).

Orientation: While I use a variety of approaches in my therapeutic style, my guiding theories are emotionally focused therapy, experiential therapy, family systems and family of origin approaches. I take a collaborative and systemic approach as I believe that clients are the experts of their lives and a change in one individual can influence others within a couple and/or family system. I utilize a variety of techniques to best assist you in clarifying your goals for change and taking steps in the desired direction. My overall goal is to assist you in being as healthy as possible, while considering the aspects of your physical, mental, emotional, relational, and spiritual health. My hopes are that I can provide my clients with the support and tools they need to reach a fulfilling life consisting of growth, prosperity, authenticity, and happiness. Establishing a healthy and trusting therapeutic relationship where my clients feel secure, respected, heard, and understood is important to me. Therefore, I am committed to providing you with quality care to assist you in achieving your goals that we establish in therapy.

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INFORMED CONSENT

Counseling Relationship: While we work together, our sessions may be very intimate psychologically, but ours is a professional relationship rather than a social one. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. Your therapist will not accept friend requests on social networking sites, such as Facebook, Twitter, Instagram, LinkedIn, etc. You will be best served if our sessions concentrate exclusively on your concerns.

Our in-person contact will be limited to counseling sessions you arrange with me. You may leave messages for me at 817-745-4523 and I will return your call as soon as possible. **If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room.** Calls that require crisis management will be brief to stabilize the situation for processing at your next scheduled appointment.

Emails: For your protection, I advise emails to be limited to dealing with typical office matter such as scheduling or billing questions. Email is not a secure form of communication and your confidentiality cannot be guaranteed. All other matters should be discussed during your session time.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas Department of Health, 512-834-6658.

Conditions of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, I may require you to sign a release so I may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services. While you are in counseling with me you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with me and sign a release that enables me to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against my advice, I may consider this your decision to change counselors and I reserve the right to terminate your counseling.

I also reserve the right to postpone and /or terminate counseling of clients who come to session under the influence of alcohol or drugs. In addition, I reserve the right to terminate counseling of clients who do not comply with the medication recommendations of their psychiatrist or physician.

Referrals: I recognize that not all conditions presented by clients are appropriate for treatment at this facility. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and /or alternatives. Certain aspects of treatment may require evaluation through psychological testing or medication. In such cases, a referral to a psychiatrist or medical doctor may be made. Ongoing dialogue with these professionals would be maintained to manage the counseling process effectively.

Fees: In return for a fee of $120 per one hour session, I agree to provide counseling services for you. If the fee represents a hardship to you, please let me know. The fee for each session will be due and must be paid at the beginning of each session. Credit cards, Cash or personal checks made out to Buchanan Couples & Family Therapy, PLLC or Dr. Barbara Buchanan are acceptable for payment. I do not file for reimbursement from health insurance companies but at your request can provide a receipt for you to follow up with your insurance provider.

If you become involved in litigation that requires my participation, and due the complexity and difficulties of legal involvement, I charge **double** my session rate per hour for preparation for and/or attendance at any legal proceedings.

Cancellation: If you will not be able to keep an appointment, please notify me at least 24 hours in advance, whenever possible. Failure to do so will result in you being billed your normal rate for the missed session. If you intend to discontinue counseling, please inform me immediately so a termination session can be scheduled and your case closed.

Format: Most sessions will be weekly and will last between 45 to 50 minutes. For couples, the option is available to participate in double or even triple sessions for a reduced fee. This option has been shown to have tremendous results in a shorter amount of time. Please feel free to discuss these options more with me if you would like more detail.

Records and Confidentiality: All our communication becomes part of the clinical record. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist: a) I am using your case records for purposes of supervision and professional development. In such cases, to preserve confidentiality, I will identify you by first name only; b) I determine that you are a danger to yourself or someone else; c) you disclosed abuse, neglect, or exploitation of a child, elderly, or disabled person; d) you disclose sexual contact with another mental health professional; e) I am ordered by a court to disclose information; f) you direct me to release your records; or g) I am otherwise required by law to disclose information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress.

Agreement

I have read the above and accept the foregoing policies. A copy of this form is valid as the original. I certify that I am an adult over sixteen years of age and consent to the above conditions for therapy.

_____	_____
Client's Signature	Counselor's Signature
_____	_____
Client's Signature (Parent, Guardian, Legal Representative)	Date

GENERAL INFORMED CONSENT FOR THERAPY

Clients usually enter counseling because they seek some positive benefits. Psychotherapy and counseling have some risks as well as benefits. Just talking about your history and concerns can have both positive and negative effects. I want to inform you of the possible risks as well the potential benefits as you begin therapy. During the first session, I will confirm with you in writing your understanding of the limits of confidentiality, the risks and benefits of verbal therapy, and the expectations of you as a client.

I will determine with you the methods, goals, or objectives of your counseling after I have collected some of the history regarding the issues. Any type of therapy will have certain benefits and specific risks associated with it. When I recommend a definite type of therapy, I will discuss the reasons for choosing that type of method. I will also discuss any additional benefits as well as risks associated with my recommendations. If the situation warrants, I may recommend other types of care including a referral to your family physician for an evaluation. It is your decision whether to follow my recommendation.

The most universal concerns of my clients are difficulties with depression, anxiety, and problems with interpersonal relationships. Most of my clients enter counseling because they want to change some of their own behavior. In the following paragraphs, I have summarized some of the usual benefits that my clients experience with counseling. I have also identified some of the risks associated with almost any kind of verbal therapy.

Potential benefits of therapy

1. Improved understanding of self and others. The objective viewpoint of the therapist helps many clients better understand their own feelings and behavior as well as those of others.
2. Progress toward defined goals and objectives. In therapy, the clients and therapist work together to set specific goals and objectives. A way is usually identified to measure progress toward those goals. Most clients can clearly identify the changes in feelings and behavior that they make through therapy.
3. Greater sense of control over moods and behavior. As clients measure progress and identify the tools used to make headway, they often gain feelings of power over moods and behavior.
4. Improved self-esteem. With greater self-control, clients often improve their self-concept. Confronting and managing one's difficulties often leads to improved self-esteem.
5. Improved self-assertion. Many clients increase their ability to assert themselves. As self-esteem and feelings of self-control improve, they feel more able to stand up for their own rights without infringing on the rights of others.
6. Improved relationships with others. By reducing unwanted behaviors and increasing more desirable behaviors, clients often improve relationships with family members or co-workers or friends.
7. Improved capacity for independence. Before therapy many of my clients may have depended on others for their sense of well-being. Therapy may lead to an increased ability to meet one's own needs.

Potential risks of therapy

1. *Lack of progress.* Some clients do not appear to improve in therapy. For example, depression or anxiety may become worse. I will monitor your progress with you to determine if this happens and to plan alternatives should this occur. In some cases I may recommend a different form of care or may suggest care by another provider or provide referrals to other providers.
2. *Upsetting insight.* Therapy may lead to insight into your own behavior or the behavior of others that is upsetting. Some clients, following therapy, wish they had not discovered some things about themselves or others. Of course, once you are aware of new information, there is no going back. I will monitor your feelings with you and discuss these concerns if they arise.
3. *Feelings of distress.* Discussing personal concerns can be upsetting by itself. Clients may experience feelings of sadness, anger, anxiety, or depression in talking about their personal or family difficulties. Clients may also have bad dreams or nightmares because of talking about concerns. Part of therapy often involved learning to handle such feelings more effectively when they occur. I will work with you to develop coping strategies for these feelings if they arise.
4. *Change in relationships.* Although behaviors and moods may change in a way that the client desires, others may not like the changes and may not adjust to the changes the client makes. Improvements in client's self-esteem, self-assertion, or sense of self-control may negatively affect others. Verbal therapy can lead to conflict in marriage or other family relationships. Sexual relationships can deteriorate. Sometimes verbal therapy can lead to divorce. Therapy may also lead, in rare cases, to deterioration of relationships at work and can result in the loss of a job. In some cases, the client decides to make changes in the family, to seek divorce, or to change jobs. However, other individuals with whom the client has a relationship may initiate changes when the client does not want to do so. I will work closely with you to try to anticipate such problems in therapy. However, we cannot anticipate all interpersonal conflicts that may result from therapy.

Regarding online therapy and consultations, every effort will be made to protect our communications and our sessions. But it must be noted, as with all online communication, some risks may still be present. Regarding any conversations, we have via email, it is best to keep communication brief, as most emails servers are not secure. Regarding our sessions online, while Skype and Google Talk are encrypted, there is still a slight risk involved with our conversations. With these noted exceptions, every step has been, and will be taken to ensure confidentiality.

I have reviewed the risks and benefits of general verbal therapy as explained in this document. My therapist has adequately answered any questions I have regarding these risks and benefits. I agree to enter verbal therapy with an understanding of the possible risks. I further understand that my therapist will explain any additional specific risks and benefits associated with any particular method, goals or objectives she may recommend.

_____	_____	_____
Client name (Print)	Signature	Date
_____	_____	_____
Client name (Print)	Signature	Date

I have interviewed the above-named individual(s) and have answered any questions about the risks and benefits of general verbal therapy. Based on my interview I have no reason to believe that he/she or they are not competent to understand the nature of verbal therapy and the potential risks and benefits that may result from it.

Dr. Barbara Buchanan, LMFT-A	_____	_____
Provider name	Signature	Date

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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective August 1, 2004

Use and disclosure of protected health information for the purposes of providing professional counseling services is sometimes required. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Treatment
Use and disclose health information to:

- Provide, manage or coordinate care to consultants, referral sources, or physicians.
- As patients gives permission via "Informed Consent" form.

Healthcare Operations

- Use and disclose health information for:
- Review of treatment procedures.
- Review of business activities.
- Staff training and care within our practice.
- Compliance and licensing activities.

Other Uses and Disclosures Without Your Consent

- Mandated reporting.
- Emergencies.
- Criminal damage.
- Appointment scheduling.
- Treatment alternatives.
- As required by law.

By signing below, you attest that you have read and have been made aware of my rights of confidentiality as a mental health consumer. Full HIPPA Compliance Rules and Regulations are posted in the therapist's office at all time, and may be read and copied for consumer upon request.

_____ _____
Client/Guardian Printed Name Relationship to Client

_____ _____
Client/Guardian Signature Date Signed

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INTAKE FORM

Name of Client _____

Social Security No. _____ Driver's License No. _____ State: _____

Date of Birth _____ Age _____ Sex _____ Race _____ Religion _____

Street Address _____ Home Phone _____

City _____ Zip _____ Cell Phone _____

Email _____

Employer _____ Work Phone _____

Job Title _____ Education (Yrs. Completed) _____

Marital Status (Circle): Single / Married / Separated / Divorced / Widowed / Cohabitating
Name of Spouse _____ No. of years married _____

Spouse Information (if applicable)

Date of Birth _____ Age _____ Sex _____ Race _____ Religion _____
Street Address _____ Home Phone _____
City _____ State/Zip _____ Work Phone _____
Employer _____ Education (Yrs. Completed) _____
Job Title_____

Children Full Name	**Sex**	**Age**	**Comments**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is currently living in your home?
_____

Who referred you to counseling? _____ _____ Referral Date _____

How did you find me? _____

Why are you currently seeking counseling? _____
_____
_____

List your current concerns in the order of their importance _____
_____
_____

Is there a history of any of the following? (Please check all that apply)

- ○ Suicide Attempts
- ○ Major Depression
- ○ Anxiety
- ○ Domestic Violence
- ○ Drug or Alcohol Abuse (Self or Family)
- ○ ADD / ADHD
- ○ Grief Issues
- ○ Sexual Abuse
- ○ Contact with Child Protective Services (or similar agency)
- ○ Other_____

What do you hope to gain from counseling now? _____
_____

Have you had any previous counseling? _____ If so, where and when and regarding what issues?

Name of previous therapist _____ Address _____

Dates of therapy? From _____ To _____ City _____ State/Zip _____

Issues of concern
_____

Reason for termination of therapy
_____

Medical History

Physician's Name_____

Address _____ City _____ State/Zip _____

Current Medications
_____

Check the behaviors and symptoms that occur to you more often than you like them to take place:

_____ aggressions
_____ alcohol dependence
_____ anger
_____ antisocial behavior
_____ anxiety
_____ avoiding people
_____ chest pain
_____ depression
_____ disorientation
_____ distractibility
_____ dizziness
_____ drug dependence
_____fatigue
_____hallucinations
_____heart palpitations
_____high blood pressure
_____hopelessness
_____impulsivity
_____irritability
_____judgment errors
_____loneliness
_____memory impairment
_____mood shifts
_____panic attacks
_____ sexual difficulties
_____sick often
_____sleeping problems
_____speech problems
_____suicidal thoughts
_____thoughts disorganized
_____trembling
_____withdrawing
_____worrying
_____other (specify)
_____cutting
_____

_____ eating disorder	_____phobias/fears	_____
_____ elevated mood	____recurring thoughts	_____

List additional illness, physical conditions or complaints:

_____

_____

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INFORMED CONSENT FOR VIDEO RECORDING THERAPY SESSIONS

Dr. Barbara Buchanan, is a Licensed Marriage and Family Therapist-Associate, board certified and licensed by the Texas State Board of Examiners of Marriage and Family Therapists and, is practicing under supervision for my LMFT-Associate license under Dr. Corey Allan, LPC-S, LMFT-S. As part of the supervision experience LMFT-Associates on occasion may be required to select videotapes of various sessions for review in and during individual and group supervision between the student, of associates, and the professor. The purpose of these videotaped sessions is to provide the associate with feedback and evaluation on how they conduct therapy sessions; it is an opportunity for the therapist to expand ethically as well as professionally for the benefit of therapist's clients.

Your therapist will always inform and ask you before session if videotaping is permissible and it will never be done without your prior knowledge or consent. All recordings can be viewed by you, the client.

I (name) _____ authorize my therapist, Dr. Barbara Buchanan, to videotape my treatment interviews as an integral part of my consultation and therapy. I understand that the use of my audio or videotapes will be restricted to the purposes mentioned above. I understand that the interviews, recordings and reports will be used solely for the purposes described above in accordance with the ethical standards of professional confidentiality for licensed mental health professionals. I further understand that should I wish it, at my written request, these tapes will be destroyed.

_____	_____	_____
Client name (Print)	Signature	Date
_____	_____	_____
Client name (Print)	Signature	Date

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CREDIT CARD AUTHORIZATION AGREEMENT

Providing credit card information is optional. Credit card information will be kept on file and used as payment for your therapy sessions. Other forms of payment include cash and check.

"By signing below, I authorize my credit card to remain on file and used for the purposes of counseling services with Dr. Barbara Buchanan for the below patient. Should I fail to give 24-hour cancellation notice, this card may be used without notice as payment for the late cancelled session."

By signing this agreement, I am authorizing Dr. Barbara Buchanan or Buchanan Couples & Family Therapy PLLC to bill my credit card, health savings account card, flexible insurance spending account card, checking account or debit card for all professional services rendered to me, my spouse or on behalf of my minor children or other family members. I acknowledge that I have read and agree to Section 7 located on the Informed Consent regarding session fees, debt collections and court proceedings. I agree not to dispute any charges which may include but are not limited to the following:

Returned check fee of the initial check dollar amount and additional $40 fee. **Initial** _____

Any insurance deductibles, administrative fees, co-pays or excluded services or other charges not directly reimbursed by Dr. Barbara Buchanan or Buchanan Couples & Family Therapy PLLC from my/our health insurance plan. **Initial** _____

I agree that telephone contact with Dr. Barbara Buchanan or Buchanan Couples & Family Therapy PLLC in excess 15 minutes other than that associated with normal scheduling services will be billed at the rate of $30.00 per 15-minute period. **Initial** _____

I agree to pay the cancellation fee equal to the cost of the session for a missed appointment if I have not cancelled with 24 hours' notice before the scheduled appointment date in accordance with the cancellation policy. No exceptions may be provided. **Initial**_____

I agree in allowing Dr. Barbara Buchanan or Buchanan Couples & Family Therapy PLLC to charge my account if there are late payments, whether it is due to client, therapist or technological error or that any outstanding payments may be sent to a collections agency, without notice from therapist after 3 unsuccessful attempts to collect payment. **Initial** _____

PREFERRED FORM OF PAYMENT:

Card Type: MasterCard____Visa____Discover____American Express____

Health Savings Account Card_____ Flexible Savings Account

Card_____Checking Account ____

Card Number:_____

Expiration Date: _____

Name as Printed on Card: _____

Security Code: _____

Routing Number: _____

Checking Account Number: _____

Billing Address: _____

City:_____State:_____Zip Code: _____

Cardholder Printed Name:

_____

Cardholder Signed Name:

_____

Client Printed Name:

_____

Date: _____