DISCLOSURE/CONSENT/POLICY STATEMENTS

The following disclosures are intended to inform you of the policies and the therapy practices of Dr. White and Associates (DWA). Please read this information carefully before you sign this consent. If you have any questions, please ask your therapist.

1. We respect your time and endeavor to always be on time to give you your full 50-minute session. We ask that you give mutual respect for our professional time. A scheduled appointment reserves that time for you. I UNDERSTAND that if I need to cancel my scheduled appointment, I must provide 24 hours' notice prior to the scheduled appointment time for a one-hour appointment and a 3-business-day notice prior to the scheduled appointment time for two or more hour appointments. I AGREE to pay the full session fee for missed appointments (no-show without cancellation) regardless of the reason, and one-half of the session fee for late cancellations (within 24 hours of the scheduled appointment time for one-hour appointments and within three business days for two-hour or longer appointments) regardless of the reason. I UNDERSTAND that I will be considered as a no-show at 15 minutes past the scheduled appointment time. I UNDERSTAND that cancellations must be made by voicemail, email, or through the online scheduling portal at dwatherapy.com. I ACCEPT the responsibility of notifying DWA if/when my appointment reminder preferences or reminder contact information changes. I ACCEPT responsibility for my appointments regardless of receipt of reminders.
2. A primary commitment of DWA is to provide you with quality services. However, no therapist can guarantee that their services will be effective for you. This disclosure is intended to convey pertinent information regarding our services, allowing you to make choices based on correct information. All our therapists have earned either Master's or Doctoral level degrees or are in the process of completing them. They are licensed by the Texas State Board of Examiners of Marriage and Family Therapists, are working toward licensure under a licensed supervisor, or are working under a licensed supervisor in a clinical internship program. We endeavor to maintain a high level of competence and we adhere to professional, legal, ethical, and moral standards. We seek to integrate cognitive, emotional, behavioral, relational, spiritual, and physical health elements in the therapy process. A variety of techniques and approaches are used. If you have any questions regarding your therapist's training or professional approach, please ask your therapist or email Dr. Mark White. Complaints about a licensed professional may be addressed by contacting the Texas State Board of Examiners of Marriage and Family Therapists at www.bhec.texas.gov/discipline-and-complaints/index.html.
3. DWA therapists are credentialed as follows:
    1. Dr. Mark White: Licensed Marriage and Family Therapist-Supervisor, Licensed Sex Offender Treatment Provider
    2. Tim White: Licensed Marriage and Family Therapist, Licensed Sex Offender Treatment Provider
    3. Adrienne Rains: Licensed Marriage and Family Therapist Associate
    4. Kayli Beaty: Licensed Marriage and Family Therapist Associate
    5. Kathryn Moore: Licensed Professional Counselor Associate

    6. Amanda Axelrod: Marriage and Family Therapist-Intern
    7. Kat O'Keefe: Marriage and Family Therapist-Intern
    8. Alyssa Hyland: Marriage and Family Therapist-Intern
    9. Hollyn Hadaway: Marriage and Family Therapist-Intern
4. DWA does not provide childcare services for parents attending appointments. Parents/guardians must accompany children. I UNDERSTAND that my children are fully my responsibility while on the DWA premises. I UNDERSTAND that the DWA receptionist will not watch over children in the waiting room. I ACCEPT responsibility for my children's behavior if left alone in the waiting room.
5. The fee for services is $75 - $200 per 50-minute session depending on the therapist. I UNDERSTAND that my fees must be paid out of pocket at the time of service. I AGREE to pay the fee associated with the therapist I have selected prior to or at the beginning of the session.
6. I AGREE to pay an additional charge of $25 for checks returned for insufficient funds.
7. I UNDERSTAND that I will be charged for any professional time required of my therapist. I AGREE to pay for my therapist's professional time in a minimum of 15-minute increments for:
    1. communications (phone, email, texts) to/from me, to/from my attorney, or to/from others involved in my case.
    2. file review, research, and preparation for meetings, court, etc.
    3. reviewing deposition transcripts.
    4. file preparation for a Release of Information request, including redaction time.
    5. transcription of hand-written notes to typed.
    6. letters written on my behalf.
8. I UNDERSTAND that if my therapist receives a subpoena from my attorney, is verbally requested by my attorney, or is requested by me to schedule my therapist's appearance in court, virtual court, or for a deposition, I will be charged $200 per hour for my therapist's time, at a four-hour minimum charge, plus one hour of preparation time, plus additional hours as requested by me, the court, or my attorney. Thus, the minimum fee for scheduling court or a deposition is $1000.
9. I UNDERSTAND that my therapist will not schedule a court appearance without advance payment. I AGREE to pay the fee at the time of scheduling or when a subpoena is served.
10. I UNDERSTAND that scheduling is only for a specified date, time, and location. I agree to provide a reasonable planning/scheduling time of three business days prior to the specified date and time of appearance.
11. I UNDERSTAND that the fee is a non-refundable fee for my therapist's scheduled time. If the court date is canceled or rescheduled and my therapist is given less than a three-business day notice of that cancellation (a Monday 9:00 am appearance must be canceled prior to the preceding Wednesday at 9:00 am). I FURTHER UNDERSTAND that it is MY responsibility to notify my therapist if the scheduled appearance is canceled.
12. I AGREE to pay for travel time to and from the scheduled appearance at my therapist's hourly rate.

13. I UNDERSTAND that I will be charged for the entire time for travel and time spent at the courthouse or deposition location, not just the time my therapist spends on the proceeding.
14. I UNDERSTAND that I will be charged as described above even if my therapist appears and is not asked to testify.
15. I AGREE to provide a copy of any and all court documents that may impact me or my family in any way during my time as a client of DWA.
16. I UNDERSTAND that content obtained in the therapy sessions is protected health information (PHI) and electronic protected health information (ePHI), which will be handled professionally and confidentially. This information will be used by your therapist and their supervisor only for your specific treatment needs.
17. I UNDERSTAND that DWA provides full-service mental health care through several therapists. These therapists may also treat other members of my family listed in this intake package. I AGREE that my PHI and ePHI may be released to other therapists and other members of my family listed in this intake package as deemed appropriate for treatment by therapists in the DWA organization.
18. I UNDERSTAND that my PHI and ePHI may be released to obtain payment for the services I receive. However, this information will be disclosed either to my responsible party for paying or for bill collection only to the extent necessary to obtain reimbursement for the services provided to me. I AGREE to release my PHI and ePHI as necessary for my therapist to obtain payment.
19. I UNDERSTAND that assessments are PHI/ePHI that require professionally-trained interpretation of the raw data. I UNDERSTAND that DWA will not release assessment raw data.
20. I UNDERSTAND that a signed Release of Information form is required for each person in the record in order to provide copies of a record. If records are requested that include information regarding other parties for which there is not a signed Release of Information, I UNDERSTAND that the information will be redacted at my expense.
21. I UNDERSTAND that there are legal limits regarding PHI and ePHI confidentiality. I AGREE to forfeit confidentiality for any of the following:
    1. If I appear to be under the influence of a substance that may impact my ability to participate in therapy, as determined solely by my therapist's judgment.
    2. If I appear to be under the influence of a substance that may impact my ability to operate a vehicle as I attempt to leave the premises, as determined solely by my therapist's judgment.
    3. If I pose serious physical danger to myself or another person, as determined solely by my therapist's judgment.
    4. If I disclose that I or another person has physically or sexually abused, molested, or neglected a child, an incompetent or disabled person, or an elderly person.
    5. In defense of any claim or complaint alleged against my therapist or DWA for which my information is determined to be relevant.
    6. Reporting to relevant agencies such as courts and insurance companies as may be ordered by the court system or for third-party payment.
    7. If I disclose that I have committed a crime.

8. If my therapist determines that a 911 call is necessary during my session.

22. Federal law requires that your PHI and ePHI be managed in specific ways. Our in-house procedures conform to these requirements. However, communication by email, phone, text, and/or audio/video telehealth requires further disclosure. These communication methods by your therapist will comply with laws governing PHI and ePHI. Use of these methods by you poses a low risk of your PHI and ePHI being accessed by a third party. If you choose to communicate with us by/through these methods, you are indicating that you accept this risk. If you desire to not accept this risk, we must maintain our communication at the face-to-face level except for scheduling. I UNDERSTAND these risks and I AGREE to accept the risk when I choose to communicate in these ways. In order to receive appointment reminders, ensure that emails from appointmentreminders@therapyportal.com can be received on your device.
23. I UNDERSTAND that I will never be asked by DWA to post on social media. However, if I voluntarily post on social media and/or on rating websites, e.g., Google, Facebook, Yelp, etc., about my experience with my therapist, I UNDERSTAND that I may reveal myself as a client, which represents my voluntary release of my PHI and ePHI. If I choose to post on social media, I ACCEPT full responsibility for the release of my PHI and ePHI. Further, by posting on social media, I AGREE that I am authorizing the release of my PHI and ePHI.
24. If I have authorized text, email, and voicemails to be used to receive communication, I also AGREE to check those messages. Further, I AGREE to leave a voicemail if I am unable to reach the DWA receptionist or therapist I attempt to contact.
25. For mutual convenience and safety, DWA will securely save my credit card information for future use from the card I used to pay today instead of swiping my card at every visit. I AGREE for DWA to process my credit card per the authorization form.
26. I UNDERSTAND that parental consent is required for mental health treatment of anyone under 18. If there are minors attending therapy addendum documents will need to be signed.

I UNDERSTAND that parental consent must be granted by a legal guardian with the independent right to consent to psychological treatment, by all guardians with joint rights to consent to psychological treatment, or by the guardian with the exclusive right to consent to psychological treatment for clients under the age of 18. I UNDERSTAND that if my independent right to consent to psychological treatment has been altered by any court-ordered arrangements, a copy of the signed court order must be provided prior to services.
I also AGREE to provide any future orders that may impact my parental rights in any way.

1. I UNDERSTAND that audio and/or video recording of a therapy session by myself or my therapist is expressly prohibited without written consent. I AGREE that I will not record my therapy sessions.
2. I UNDERSTAND that video cameras in public areas of the DWA building are for security only.
3. I UNDERSTAND that treatment by more than one therapist at a time can be detrimental to my well-being. No one listed in this intake package has been treated by a therapist within the last 12 months except as noted on page 2 of this intake package. I AGREE to

notify my therapist if I or anyone listed in this intake engages in therapy with another therapist while in therapy with a DWA therapist.

CONSENT TO TREATMENT

I AGREE that I have read and fully understand this document in its entirety, including the disclosures, confidentiality statements, and policies of DWA. I FURTHER AGREE that my electronic signature below indicates my full acceptance of the same in their entirety. I UNDERSTAND that I am giving my informed consent to DWA to be assessed and treated. I employ DWA to provide therapy services. I UNDERSTAND that I will be provided a copy of this intake package at my request.

If there are any questions regarding privacy, disclosures, or consent; please feel free to contact Tim White at timwhite@dwatherapy.com.