PRIVATE (SELF) REFERRED

Thank you for considering Summit Family Counseling, LLC for your treatment needs. We hope that this information helps you make the choice that is best for you.

Times and Prices:
All appointments will be made according to availability.

Sessions	50 Minutes	90 Minutes
Intake (Initial appointment)	$55	$80
Individual	$55	$80
Couples counseling	$55	$80
Family	$55	$80

Couples Communication Classes $225 (Includes materials)
(Each class lasts 4 weeks at 2 hours each class)

For initial appointments, please arrive a half hour prior to your scheduled appointment to complete your paper work, or print out all paperwork and bring it with you to your appointment.

To access paperwork, click below:

How we can help you:
At Summit Family Counseling, LLC we are dedicated to helping you accomplish your goals. All sessions are confidential, and we create individualized treatment plans that focus our attention to what you want.

Appointments:
For appointment times, location, and other information, you can refer to our web home page. Or contact us at:

Office: **(702) 568-5888 ext. 225**
Bruce's Direct Line: **(702) 353-1148**
Molly's Direct Line: **(702) 353-1124**

If we are unavailable, please leave a detailed message. We'll call you back as soon as possible.

We look forward to hearing from you. Thank you.

Bruce M. Parsons, Molly E. Parsons

Bruce M. Parsons, MS, LADC, MFT-Inter, Owner of Summit Family Counseling, LLC
Molly E. Parsons, MS, MFT-Intern, Owner of Summit Family Counseling, LLC

Consent to Treatment

Welcome to **Summit Family Counseling, LLC!** Bruce is a Licensed Alcohol and Drug Counselor and Bruce and Molly are both registered as a Marriage and Family Therapist Interns. We provide individual, couple, family, and group counseling for a variety of issues. In addition, we offer Couple Communication workshops. As therapists, it is our role to assist our clients in understanding, explaining, and alleviating the cognitive, emotional, and behavioral distress described by the client. Please take a few moments to read this information regarding therapy and to sign the informed consent agreement. If you have any questions, please call/ask at any time. We look forward to getting to know you!

Thank you,
Bruce M. Parsons, M.S.
Molly E. Parsons, M.S.

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1. **Treatment:**

Treatment begins following an initial assessment/intake interview. The first several sessions are used to gather additional information in order to develop an appropriate treatment plan for you, including how often we will meet together and also including how therapy should be delivered (i.e. individual, family, and/or group sessions). This plan is formulated according to the nature and intensity of the problems you present.

Therapy requires **your active involvement** and best efforts to change thoughts, feelings, and behaviors. If it is assessed that we, nor this agency, can adequately meet your treatment needs, you will be provided referrals for other community agencies and/or private mental health practitioners who may better meet your needs. Treatment is most often terminated by mutual agreement. You may discontinue treatment at any time by informing me that you wish to terminate treatment. If you do not show for more than three consecutive sessions, we will assume that you no longer desire treatment and terminate your case. Initial__________

2. **Appointments:**

You may call Molly at 353-1148, Bruce at 353-1148, or the office at 568-5888, ext. 225, to schedule, reschedule, or cancel an appointment. The number you are calling from may appear on my monthly phone bill.

We make every effort to begin appointments on-time, and we expect our clients to be on-time as well. If you are running late for your appointment, please let us know by leaving a message.

Sessions that are lengthened by more than ten minutes will be billed according to the pay-rate of $55 per 50-minute session.

Initial__________

3. **Fees:**

Payments for therapy services are based on an hourly rate of 50 minutes and are due prior to each session. Our individual counseling fee is $55 per 50-minute session. 90-minute sessions will be billed at $80. We often recommend couples and families for 90-minute sessions, as we find it to be more effective for treatment.

If you are unable to keep your appointment, please call us **at least 24 hours** prior to your appointment, so we can make it available to another client. If you do not call at least 24 hours ahead or do not show for your appointment, we will still need to bill you for the entire session ($55 or $80).

Credit Card #______________________________ Expiration Date_________
Name on Card____
Full Billing Address____
*Signature________________________________
*Your signature authorizes us to bill this credit card for any sessions cancelled or rescheduled with less than 24 hours notice and/or for any legal-related services described below.

If there is any time spent for legal actions, you will be billed at a rate of $350 an hour for any paperwork, speaking to an attorney, court appearances, travel time, and any and all other preparations of any kind. **If your court case involves a partner that has been seen in treatment with you, you must have a written release from that person in order for me to disclose information.**

Initial__________

4. **Confidentiality**:

A record of all evaluation and treatment sessions are kept in a locked drawer. This information is confidential. Under Nevada State Law, you have the right to access the information in your medical records. Information about your treatment cannot be shared with anyone (e.g. insurance companies, attorneys, physicians, family members, or others) without your written consent. Again, if you are seen as a couple, both you and you partner are considered "the client" together, so any request to see your records would require written consent from both parties.

Certain laws and ethical standards limit confidentiality of treatment information. As marriage and family therapist interns, we are required to report suspected incidents of child and/or elder abuse (sexual, physical, neglect) to Child Protective Services and/or law enforcement authorities. If you are a danger to yourself or others, we are also required to report to the authorities. In some cases, intent to commit a criminal act may also be reported, and the court may subpoena your records.

We may talk about you to other professionals in the following instances. Due to our status as interns, we meet once a week with a supervisor and other interns to discuss cases, obtain a different point of view,

and evaluate our progress. During these supervision appointments, only pertinent information will be shared.

Because we operate as an agency, cases may be discussed in general terms with other agency counselors in order to obtain various perspectives for your benefit. Also, other counselors or clients are likely to see you in passing at the office.

If we are scheduled to be away from the office for a vacation, we may have a trusted colleague cover for us in instances of emergencies. We will tell them only what they need to know should you have an emergency while we are gone.

Except for the situations described above, our office staff, colleagues, and both of us will always maintain your privacy. **Please remember that this means we are unable to talk to anyone (including your spouse or parents) about you or your case, unless you sign a release form for that person.**

Initial__________

5. Risks/Benefits:

Therapy has been demonstrated to help many individuals, and we have personally witnessed happy stories of progress in peoples' lives as a result of counseling. Therapy is most effective when you follow through on any "homework" assignments or any other activities that we agree might be helpful. One of the primary risks of therapy is the fact that change sometimes comes quick and easy, but most often is slow and frustrating. Another risk of therapy is that the process may include discussing problems or events that may evoke unpleasant feelings. If this occurs, please inform us immediately so that these feelings may be addressed in a timely and appropriate manner. You may also notice that things might seem to get worse before they get better. This is because any type of change disrupts the set patterns you've been experiencing for so long. However, if, during treatment, things work differently than they have in the past, it is a good indication that you (and your spouse or family) are prepared for positive change.

In order for therapy to be most effective, weekly appointments are usually necessary. One risk of not keeping weekly appointments is that regression may occur during the period you are away from therapy. We encourage our clients to do everything they can to keep weekly appointments. As progress is achieved, treatment will be slowly phased-out. Sessions may be cut back to once every other week, then to once a month, etc.

Initial__________

6. **Emergencies:**

In the case of a medical emergency call 911 or in case of a psychiatric emergency call Montevista Hospital at 702-364-1111. For all over-the- phone sessions we will bill you at the same rate as in-office sessions. If you do not require an immediate phone session, an in-office session will be scheduled as soon as possible.

Initial__________

7. **The Therapeutic Relationship:**

As professionals, we will use our best knowledge and skills to help you. In your best interest, there are professional limits on the relationship between a therapist and a client, and we will abide by these limits. Therefore, it is important for us to explain these limits, so you will not think they are personal responses to you. State laws and ethical guidelines require us to keep what you tell us confidential. The limits of confidentiality were explained earlier in this document. However, this also means that if we were to meet you on the street or socially, we will not initiate a greeting. This is not a personal reaction to you; rather, it is a way to maintain the confidentiality of our relationship. If you wish to say hello to one of us, we may then respond. Likewise, if you invite us, we will not be able to attend your family gatherings including weddings, baby showers, or the like. As therapists, we will not give you gifts, and we may not receive gifts from you. We can only be your therapist. We cannot have another role in your life. We cannot be a close friend, have a romantic relationship, or conduct any business other than therapy with our clients.

Initial__________

My signature below indicates that I have read and understand the nature and limits of services provided. I agree to voluntarily participate in therapy services and will aid in the formation and completion of a treatment plan.

____ __________________

Signature of Client or Guardian Date

____ __________________

Signature of Therapist Date

Summit Family Counseling, LLC
Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: ______________________________________Date: _______________

Client Information

Today's Date: ___________________________________
Client Name: ___________________________________Date of Birth: ______________________
Client's Soc. Sec. #: ____________________________
Client's Phone # Home: (___) ____________________Cell/Work #: (___) _________________
Can a message be left? Yes_____ No_____
Client's Address: ____
City: _______________________________ State: ___________ Zip Code: __________________
Race: African American Asian Caucasian Hispanic Native American
Other: _____________
Religion: Baptist Catholic LDS Lutheran Jewish Protestant None
Other: _____________

Relationships
Is Client Married? Yes_____ No______ Length of Marriage: _________
If Not Married, with Significant Other? Yes_____ No_____ Length of Relationship: _________
Please list dates and lengths of any past marriages/significant relationships:

Type of Relationship:	Length:	From:	To:

Number of Children: _____

Names:	Ages:

If Client is a Minor:
Parent/Legal Guardian's Name(s): ____
Address: ____
City: _____________________________ State: _______________ Zip Code: _________________
Home Phone #: (_____) ______________________ Cell/Work #: (_____) ___________________

Concerns
What concerns bring you to counseling at this time?
____
____
____

What would you like to gain from counseling?
____
____
____

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Summit Family Counseling, LLC
Authorization to Release Confidential Information
(optional)

Client Name: ________________________________ Date of Birth: ____________________

I, hereby authorize **Summit Family Counseling, LLC** to contact the agency or person specifically listed on this form to exchange such information for the purpose of providing assessment, case management and/or treatment services for the client named above. The authorization also permits release of medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (P.L. 93-282). A photocopy of this form shall be as valid as the original.

Agency/Person authorized to release information:

Name ________________________________ Phone: ________________________________

Address____

City __________________________state __________________________zip___________

Records to be released____

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I understand that my records are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on my consent, and that in any event this consent expires automatically on the date stated below or upon termination of the services for which the consent was granted, whichever comes first.

Date of expiration (One year from date signed) ______________________________

Person signing authorization:

________________________________	________________________	_____________
Client or Guardian (print please)	Signature	Date

Witness:

________________________________	_______________________	_____________
Name (print please)	Signature	Date