Deanna Sims, Ph.D.
Licensed Professional Counselor
15443 Knoll Trail Drive, Suite 210 Dallas, TX 75248
972-978-2157 www.DrDeannaSims.com

Professional Disclosure Statement

Qualifications: I am a Licensed Professional Counselor with a doctoral degree in counseling. My formal education and professional experience have prepared me to counsel individuals, groups, couples, and families.

Nature of Counseling: I believe all people have the potential for growth, change, and healing. Humans are social creatures that need social connection in relationships to maintain health. I believe that people's feelings, thoughts, and behaviors are created by how they subjectively experience their surroundings. People use their behaviors to achieve goals. I also believe that all people at any time in their lives, have the ability to change their emotions, thoughts, behaviors and goals. I will use a variety of strategies (cognitive behavioral techniques, homework assignments, self-exploration strategies, bibliotherapy, Socratic questioning, encouragement, and others) in the therapy process. I invite you to establish goals and explore how your thoughts, behaviors, and feelings are working to meet those goals. If you desire a change in your feelings and behaviors, through self-exploration and thought modification, we can work as a team to meet your treatment related goals.

INFORMED CONSENT

Counseling Relationship: Sessions are held for 45-53 minutes, depending on your healthcare plan provisions. Although our sessions may be very intimate psychologically, our relationship is a professional one rather than a social one. Ethical guidelines prohibit counselors from receiving gifts. Our contact will be limited to counseling sessions you arrange with me, except in case of emergency, when you may contact me by phone. I will be unable to accept friend requests through social media (Facebook, Linked-In, etc.) Email or text messages may be used for scheduling or brief questions. My preference is for you to call if you are having a problem so I may speak to you directly.

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 a personal exploration and may lead to major changes in your life perspective and decisions you make. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these insights or 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 only need a few counseling sessions to achieve their goals; others may require months or even years of therapy. As a client, you are in complete control and may end our counseling relationship at any time, though I do request you participate in a final termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might not be beneficial to you.

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 State Board of Examiners of Professional Counselors at (512) 834-6658.

Referrals: Should you and/or I believe that a referral is needed for more in depth or specialized treatment, 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.

Fees: In return for a fee of $150 per session, I agree to provide counseling services for you. The fee for each session will be due and must be paid at the beginning of each session. Cash, personal checks (made to Dr. Deanna Sims), or credit cards are acceptable forms of payment. You will be responsible for any fees related to insufficient funds for returned checks. Cash payments will be required following any returned checks. Copays quoted are an estimate from your health insurance company and not a guarantee of payment. You are responsible for the fee if your insurance company does not pay your claim. Any document preparation for disability or court/mediation, court costs, depositions, or other time spent testifying, waiting to testify, including time driving to and from the court, will be billed at $250 per hour. A copy of your medical record may be obtained for a fee of $.50 per page.

Cancellation: In the event that you will be unable to keep an appointment, please notify my office at (972) 978-2157 at least 24 hours in advance. Please be aware that insurance will not cover missed or canceled appointments. Maintaining consistent therapy attendance is a very important clinical issue. It is important for me to monitor your progress and for you to be committed to the counseling process to maximize the therapeutic benefits. Missed appointments or cancellations without 24 hour notice will be billed for the full fee of $150. Missed appointment fees must be paid on or before the next scheduled therapy appointment.

Records and Confidentiality: All of our communication becomes a part of your clinical record. Adult client records are disposed of five years after the file is closed. In the event of the death or incapacitation of the counselor, records will be the property of Bent Tree Psychiatric Associates.

Most of our communication is confidential, but the following limitations and exceptions do exist: 1) I determine you are a danger to yourself or others; 2) you disclose sexual contact with another mental health professional; 3) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; 4) I am ordered by a court to disclose information; 5) you direct me to release your records; 6) I am otherwise required by law to disclose information.

In the case of marriage or family counseling, I will keep confidential (within the 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 the counseling relationship if I judge a secret to be detrimental to the therapeutic process.

I acknowledge that Dr. Sims may communicate via cell phone, text message and/or email.

By your signature below, you are indicating that you have read all pages and understand this document, and that any questions you have had about this document have been answered to your satisfaction.

***Signature of Patient*_____ *Date*_____/_____/_____**

INFORMED CONSENT

I request that Deanna Sims, Ph.D., LPC provide counseling and related services as may be prescribed. I acknowledge that counseling is not an exact science and that no guarantees have been made as to the results of the treatment hereby authorized.

***Signature of Patient*_____ *Date*_____/_____/_____**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Dr. Deanna Sims' *Notice of Privacy Practices*. This notice describes how Dr. Deanna Sims may use and disclose my protected healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

***Signature of Patient*_____ *Date*_____/_____/_____**

RECIPROCAL CONSENT TO RELEASE CONFIDENTIAL INFORMATION

This document authorizes Deanna Sims, Ph.D., LPC and the following individuals to disclose and exchange information regarding patient, _____.

☐ Health Insurance Plan

☐ Primary Care Physician _____

☐ Psychiatrist _____

☐ Other Healthcare Provider _____

☐ Other Healthcare Provider___ _____

☐ Disability Insurance Company _____

☐ Other _____

The purpose of this disclosure is for authorization of care and utilization review, payment/billing, and or coordination of care with other treatment providers.

***Signature of Patient*_____ *Date*_____/_____/_____**

Name _____ Date of Birth_____/_____/_____
Address_____City_____, TX Zip_____
Phone_____ Email _____
Healthcare Plan _____ ID#_____