

*Suzy Gadol Anderson, LCSW*

*Licensed Clinical Social Worker*

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### **Professional Disclosure Statement**

**Qualifications:** I am a Licensed Clinical Social Worker. My formal education and professional experience have prepared me to counsel individuals (adolescents, adults, and the elderly), groups, couples, and families.

**Nature of Counseling:** Humans are social creatures that need connection in relationships to maintain and enhance their health. Since people's feelings, thoughts, and behaviors are created by how they perceive their surroundings and events in their life, people use their behaviors to achieve goals. All of us at any time in our lives have the ability to change our emotions, thoughts, behaviors and goals. We may not have been taught how to achieve these changes, and seeking out therapy can help you to have the kind of life that you want to have. While working with you, I will use a variety of techniques (homework assignments, self-exploration strategies, Socratic questioning, identification of distorted thinking, encouragement, and others) and invite you to establish goals and explore how your behaviors and emotions are working to meet those goals. I wish I could make all of your problems dissolve away, and I can't do the work for you. However, we will work as a team to meet your treatment related goals, and our relationship needs to be based on honesty to make this happen. The information shared in sessions and work done outside of sessions deeply affects your success in treatment.

### **INFORMED CONSENT**

**Counseling Relationship:** Although our sessions may be very intimate psychologically, our relationship is a professional one rather than a social one. Our contact will be limited to counseling sessions you arrange with me, except in case of emergency when you may contact me by phone. Gifts, bartering or trading services may complicate the therapeutic process and generally are not appropriate between you and your therapist.

**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 life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work through your reactions in therapy to achieve the best possible results. The overall goal is for you to feel better.

**Goals:** To begin the therapeutic process, please list a goal or goals that you would like to accomplish in treatment. These may change over time, and can be revised as needed.

1. \_\_\_\_\_
2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Client Rights:** Some clients only need a few counseling sessions to achieve their goals; 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 request you inform me that you would like to terminate our therapy and 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 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 notify me in person or in writing and I will work with you to resolve your concerns. It is my pledge that any problems will be resolved to your satisfaction.

**Referrals:** As we progress, you and/or I may believe that a referral to a different type of treatment or provider is needed. I will provide some alternatives, including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives. A verbal exploration of alternatives to counseling can also be made available upon request. I may also recommend other types of assistance in conjunction with our working together.

**Length of sessions and fees:** In return for a fee of \$140 per session for individual therapy, \$150 per session for support outpatient program (SOP), \$165 per session for couples & marital therapy, & \$200 per session for family therapy, I agree to provide counseling services for you. **Sessions are usually held for 50 minutes for individual sessions, 90 minutes for marital and family sessions, and 2 ½ hours for SOP. It is my office policy that payment for each session must be paid at the beginning or conclusion of each session.** Credit, debit or health spending cards, cash or personal checks (made to Suzy Gadol Anderson) are acceptable forms of payment. If the fee represents a hardship for you, please let me know so we can discuss these rates. If you would like a longer session, addition fees will be added. Any document preparation, court costs, depositions, or other time spent testifying, waiting to testify, including time driving to and from the court, will be billed at \$200 per hour. A copy of your medical record may be obtained for a fee of \$100.

**Cancellation:** In the event that you will be unable to keep an appointment, please notify my office at (214) 552-9958, at least 24 hours in advance. Please be aware that insurance will not cover missed or canceled appointments. **Missed appointments or cancellations without 24 hour notice will be billed for the full fee.** Please inform me if you have a severe illness or inability to contact me if you miss an appointment so we can discuss this policy.

**Records and Confidentiality:** All of our communication becomes a 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: 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, family or group 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.

**Therapist's Incapacity or Death:**

In the event the therapist becomes incapacitated or dies, the confidentiality of your chart and treatment information will not change, and the records will not be released without your consent.

**Client Rights:**

**Complaints:** 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 any complaints to the Complaints Management and Investigative Section, P.O. Box 141369 Austin, Texas 78714 or by calling 800-942-5540.

**Suggestions:** You are invited to suggest changes in any aspect of the services I provide.

**Civil Rights:** Your civil rights are protected by federal and state laws.

**Cultural/spiritual/gender issues:** You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, I will assist you in the referral process.

**Treatment:** You have the right to take part in formulating your treatment plan.

**Denial of services:** You may refuse services offered to you and be informed of any potential consequences. I may also refuse or rescind this offer to provide counseling.

**Record restrictions:** You may request restrictions on the use of your protected health information; however, I am not required to agree with the request.

**Availability of records:** You have the right to obtain a copy and/or inspect your protected health information; however I may deny access to certain records in which I will discuss this decision with you.

**Amendment of records:** You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.

**Medical/Legal Advice:** You may discuss your treatment with your doctor or attorney.

**Disclosures:** You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

**Your rights to receive information:**

**Costs of services:** I have informed you of your deductibles, copays, and terms/limitations of your healthcare policy.

**Termination of services:** Physical or verbal threats or acts of violence constitute my right to terminate services. If I do not feel qualified to assist you with your issues, I may suggest termination and referral to another provider. I reserve the right to decide what constitutes my and your rights to termination of services on an individual basis. If you decide to terminate services, I request that we have a final session before ceasing to meet to discuss the reasons, assist in improving my skills and possibly reconsider termination.

**Confidentiality:** You have been informed of the limits of confidentiality and how your protected health information will be used.

**Policy changes:** You will be informed in writing of any policy changes.

**Therapist's ethical obligations:**

I dedicate myself to serving the best interest of each client.

I will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences or other personal concerns.

I maintain an objective and professional relationship with each client.

I respect the rights and views of other mental health professionals.

I will end services or refer clients to other services when appropriate.

I will evaluate my personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. I will continually attain further education and training.

**Patient's responsibilities:**

You are responsible for your financial obligations.

You are responsible for following the policies.

You are responsible to treat me and fellow patients in a respectful, cordial manner in which their rights are not violated.

You are responsible to provide accurate information about yourself.

By your signature below, you are indicating that you have read and understood this statement, and that any questions you have had about this statement have been answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

2<sup>nd</sup> Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

(If client is a minor under age 18)

Therapist \_\_\_\_\_ Date \_\_\_\_\_