

Corey D. Allan, Ph.D. and Associates
Licensed Marriage and Family Therapist

PROFESSIONAL DISCLOSURE STATEMENT Therapy Policies 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.

Qualifications: I am a graduate from Texas Woman's University in Family Therapy and the University of North Texas in Counselor Education. I am qualified to counsel according to the Texas Department of Health. My formal education has prepared me to counsel individuals, groups, couples, parents, and families. I am a member of the American Association of Marriage and Family Therapists and American Association of Christian Counselors.

Experience: Throughout my doctoral and master's program and under supervision since completing my formal education I have counseled many individuals, couples, families and conducted many groups. I am also a certified trainer in the Love and Limits Parenting approach from the Savannah Family Institute.

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. 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 214-629-6133 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.

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.

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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 by the conclusion of each session. Visa, Mastercard, Cash or personal checks made out to "Dr. Corey Allan" are acceptable for payment. I do not file for reimbursement from health insurance companies but you may request the required information be given in order 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: In the event that 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. Couples may also choose the **Intensive Therapy** option, typically occurring on four consecutive days in the morning or afternoon. Please feel free to discuss these options more with me if you would like more detail.

Records and Confidentiality: All of 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.

Client's Signature

Counselor's Signature

Client's Signature

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 as a result of talking about

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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 he 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. On the basis of 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.

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Provider name

Signature

Date

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. _____ Drivers 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 / Cohabiting
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 _____

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

- | | |
|--|--|
| <input type="checkbox"/> Suicide Attempts | <input type="checkbox"/> ADD / ADHD |
| <input type="checkbox"/> Major Depression | <input type="checkbox"/> Grief Issues |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Contact with Child Protective Services
or similar agency |
| <input type="checkbox"/> Drug or Alcohol Abuse
(Self or Family) | <input type="checkbox"/> Other _____ |

What do you hope to gain from counseling at this time? _____

Have you had any previous counseling? _____ If so, where and when and with regard to 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 | _____ fatigue | _____ sexual difficulties |
| _____ alcohol dependence | _____ hallucinations | _____ sick often |
| _____ anger | _____ heart palpitations | _____ sleeping problems |
| _____ antisocial behavior | _____ high blood pressure | _____ speech problems |
| _____ anxiety | _____ hopelessness | _____ suicidal thoughts |
| _____ avoiding people | _____ impulsivity | _____ thoughts disorganized |
| _____ chest pain | _____ irritability | _____ trembling |
| _____ depression | _____ judgment errors | _____ withdrawing |
| _____ disorientation | _____ loneliness | _____ worrying |
| _____ distractibility | _____ memory impairment | _____ other (specify) |
| _____ dizziness | _____ mood shifts | _____ cutting |
| _____ drug dependence | _____ panic attacks | _____ |
| _____ eating disorder | _____ phobias/fears | _____ |
| _____ elevated mood | _____ recurring thoughts | _____ |

List additional illness, physical conditions or complaints:

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CREDIT CARD INFORMATION

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.

Name on Card:

Card Number:

3-digit verification code (back of card)

Exp.

Circle One:

Visa

MasterCard

“By signing below, I authorize my credit card to remain on file and used for the purposes of counseling services with Dr. Corey D. Allan 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.”

Cardholder Printed Name:

Cardholder Signed Name:

Client Printed Name:
