



The Vine Wellness Group

Counseling Agreement/Informed Consent

WHO WE ARE

The Vine Wellness Group is committed to facilitating mental, emotional, relational, and spiritual change in individuals, couples and families through evaluation, counseling, and collaboration with other health professionals. This is our mission. We do not seek to impose our own theological views on our clients, but will certainly utilize our clients' own faith understandings if they can be beneficial for treatment.

LICENSED PROFESSIONAL THERAPISTS

Therapists' detailed background information can be found on The Vine Wellness website at www.thevinewellness.com.

Annie M. Viers, MA, LPC-S, LMFT-S (Sr. Therapist; Co-Owner)

Licensure: Licensed Professional Counselor, License # 19528, State of Texas

Licensed Marriage and Family Therapist, License # 5159, State of Texas

Celeste R. Inman, M.Ed., LPC-S, RPT-S (Sr. Therapist; Co-Owner)

Licensure: Licensed Professional Counselor, License #60831, State of Texas

Registered Play Therapist, Credential # T1370, US Association for Play Therapy

Brittany Christiansen, MA, LPC

Licensure: Licensed Professional Counselor, License #77655, State of Texas

Jacilyn Bondy, MS, LPC, LCDC

Licensure: Licensed Professional Counselor, License #74374, State of Texas

Licensed Chemical Dependency Counselor, License #13049, State of Texas

Janice Zitelman, LCSW

Licensure: Licensed Clinical Social Worker, License # 05611, State of Texas

LPC-ASSOCIATES/LMFT-ASSOCIATES PRACTICING UNDER THE SUPERVISION OF ANNIE AND CELESTE

Gillian Rodriguez, MA, LPC-Associate

Lindsey Jackson, MA, LPC-Associate

Shannon Porter, M.MFT, LMFT-Associate

Stephen Trotter, MA, LPC-Associate, NCC

MASTER'S STUDENTS PRACTICING UNDER THE SUPERVISION OF ANNIE AND CELESTE

Britney Vincent, Grand Canyon University Practicum Student

Rebekah Sanchez, Liberty University Practicum Student

CONFIDENTIALITY

Confidentiality means that therapists have a responsibility to you to safeguard information obtained during treatment.

Is important that you understand that all identifying information about your assessment and treatment is kept confidential. Information about your case is only shared, with your written consent, with those other professionals who might be able to enhance the services you receive.



In order to protect your confidentiality, any written, telephone, or personal inquiries about clients will not be acknowledged. You must sign a release of information before any information about you is given outside the agency.

In order for us to coordinate our treatment with other mental health or medical professionals, we will ask you to sign a release of information to allow us to discuss or correspond with other professionals who may have been involved in your care.

It is important that you understand that the laws of the State of Texas mandate exceptions to confidentiality in specific cases. According to Texas Family Code, in certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, in these situations we may not be required to inform you of our actions:

1. A mental health professional is required to report suspected child abuse or neglect and to report suspected abuse of the disabled or elderly (age 65 and above).
2. A mental health professional may be required to disclose information to law enforcement personnel in order to protect the patient or others when there is a high probability of imminent physical injury. A mental health professional may be required to disclose information to law enforcement personnel in order to protect the patient when there is a high probability of immediate mental or emotional injury.
3. A mental health professional may be required by the court to disclose treatment information in proceedings affecting the parent-child relationship.
4. A mental health professional may disclose confidential information in proceedings brought by a patient against a professional.
5. There is no confidentiality of mental health information in connection with criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
6. In the treatment of a minor client, a mental health professional may advise a parent, managing conservator or guardian of a minor, with or without the minor's consent, of the treatment needed by or given to the minor.

Confidentiality with couples and/or families is a special consideration. During treatment, the counselor may need to share information learned in an individual session (a session with only a portion of the treatment unit being present) with the entire unit- that is, the couple or family, if the counselor is to effectively serve the unit being treated. The counselor will use their best judgment whether, when, and to what extent they will make disclosures to the entire treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely do not want shared, you may want to consult with an individual therapist who can treat you individually.

I have read and agree to the above section _____

SOCIAL NETWORKING AND EMAILS

Your counselor will not solicit or accept friendship or other requests via Facebook, Linked In, Pinterest, or other similar social media platforms.

Emails sent to our counselors are to contain information regarding scheduling, ONLY. If there is any other confidential information sent by email, the counselor will not respond to it by email but will address it during your next scheduled appointment in order to maintain confidentiality.

I have read and agree to the above section _____



LITIGATION POLICY

The therapeutic process often involves making a full disclosure with regard to many matters which may be of a confidential nature. If you choose to begin legal proceedings of any kind (including but not limited to divorce and custody disputes, work-related injuries, lawsuits, etc.), you agree that neither you, your attorneys or anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court or in any legal proceeding. By your signature below, you specifically agree to abide by this condition of treatment.

If I am subpoenaed to provide records or testimony in violation of this agreement, you acknowledge and agree you will pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. For providing services in any legal matter, my hourly fee is \$250 per hour and for court appearances a \$1500 retainer fee will be collected. I will charge this rate for preparation time related to any legal proceeding, travel time from my office to the location of the proceeding, and all time spent in attendance at any legal proceeding.

If I am subpoenaed to provide records or testimony in violation of this agreement, I reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers.

I will NOT provide custody evaluations or recommendations. I will NOT provide medication or prescription recommendations. I will NOT provide legal advice. None of these activities are within scope of my practice.

I have read and agree to the above section _____

REQUESTS FOR TREATMENT RECORDS

- In the event that a client requests a copy of their treatment records, a written release of information will be filled out by the client in order to complete the request. If there is a request for the treatment records of a couple or family, we will seek the authorization of all members of the treatment unit before we release confidential treatment records to just one person of the couple and/or family or a third party. All requests for mental health care records will be granted within 15 days of written request according to the Texas H&SC 611.008.

I have read and agree to the above section _____

THE RISKS OF COUNSELING

To allow you to make an informed decision about your treatment, we will describe the possible risks of counseling. You may experience discomfort, such as anger, depression, or frustration during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not be originally intended.

The Vine Wellness Group is not an emergency service. Our therapists are not able to return your calls immediately or schedule you for immediate treatment. In the event of an emergency, please call 911, the Crisis Hotline at 210-820-3500 or go to the nearest hospital emergency room for evaluation.

The greatest risk of counseling is that it may not by itself resolve your concerns. We do our best to assess progress on a week-to-week basis. If a situation fails to improve or a situation deteriorates, we will provide referral to another professional for consultation or treatment. Positive results are not guaranteed. In the end, client decisions are self-determined.

I have read and agree to the above section _____



BENEFITS OF COUNSELING

Counseling has proven, in extensive outcome studies, to be successful in treating and helping individuals, couples and families resolve: feelings of depression, failure, anxiety, or loneliness; unmanageable anger, hostility, or violence; persistent difficulty coping with stresses arising from life crises, such as death, divorce, acute or chronic illness, or unemployment; persistent problems with a child's behavior, school adjustment, or performance; chronic work difficulties or frequent job changes; alcohol or drug abuse; repeated financial difficulties; persistent feelings of dissatisfaction with marriage or family life; sexual concerns; and drastic weight fluctuations or irregular eating patterns.

I have read and agree to the above section _____

TIME OUT OF THE OFFICE AND EMERGENCIES

Counselors at The Vine are not crises counselors. The counselors are not available for client emergencies or crises. If in a crises and need help immediately, please proceed to your nearest emergency for evaluation or Dial 911. In addition, your counselor may not work weekends, from time to time will take vacations or may be absent due to training, family emergencies, etc. Due to the nature of the job, your counselor is not always available to answer non-emergency phone calls or emails during work hours. Your counselor will do their best to return non-emergency messages and emails within 24 business hours.

In the event that Mrs. Viers or Mrs. Inman becomes incapacitated and can not practice, all client files and records will be stored with and can be accessed by the remaining counselor (Mrs. Viers OR Mrs. Inman). All client files and records of any LPC-Associate/LMFT-Associate, are the responsibility of The Vine and remain the responsibility of The Vine when the LPC-Intern/LMFT-Associate is not longer with the practice.

I have read and agree to the above section _____

FEES AND APPOINTMENTS

Fees for treatment sessions are stated on our "Fees for Services" page. If you are experiencing financial difficulty, a sliding fee scale may be offered on a limited basis. We currently do not accept any insurance or third party payers. Payment is expected at the time services are rendered. If you would like a receipt that is coded for insurance so that you may submit it to your insurance provider, please ask your counselor at the time of service.

Therapy sessions are by appointment only. If you must cancel an appointment, please give your therapist at least 24 hours notice. While we can appreciate that emergencies do arise, we do reserve the right to charge clients the full rate for missed appointments.

I agree to pay the fee of _____ per session for therapy services, and that **I can and will be charged for the same fee for a missed appointment not cancelled 24 hours in advance. Please note that if canceling by text/email with your therapist, a return response from your therapist is acknowledgment of cancellation. If you do not receive a return response from your therapist, you should assume that they did not receive your message therefore, you will still be charged for your session. If there is any uncertainty of your cancellation, please call the mainline at 210-490-4419.**

I have read and agree to the above section _____

TERMINATION OF THERAPY

You may leave therapy at any time. If you decide to discontinue therapy, please discuss your decision with your therapist. If a situation fails to improve or a situation deteriorates, we will provide referral to another professional for consultation or treatment. If a problem is outside the boundaries of our competence, (legal issues, financial planning, medication questions, etc.) we will refer you to another professional.

I have read and agree to the above section _____



HOLD HARMLESS CLAUSE

Clients and their family members agree to waiver all legal claims for damages against any churches that support The Vine Wellness Group, Annie M. Viers/Viers Family, and Celeste R. Inman/Inman Family. Your signature below means that you have read and agree to participate in counseling voluntarily without force. Furthermore, your signature means that you understand all of the information in this document and hold harmless all entities for legal, financial, and/or other compensation for results which do not meet you or your family members' stated expectations for therapy.

I have read and agree to the above section _____

COMPLAINTS

If you have any complaints or questions, please contact your counselor. If you need further assistance and they are a counseling intern please contact their supervisor Annie Viers, MA, LPC-S, LMFT-S or Celeste Inman, M.Ed., LPC-S, RPT-S. They will get back to you in a timely manner. You may also submit a complaint to the U.S. Department of Health and Human services and/or the Texas State Board of Examiners of Professional Counselors Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540 to request the appropriate form or obtain more information. This number is for complaints only. If you choose to file a complaint, we will not retaliate in any way.

I have read and agree to the above section _____

RECORDINGS

Due to the sensitive nature of the topics discussed in counseling sessions, client's confidentiality rights and HIPPA regulations, we ask that no recordings of any sessions and/or conversations with your therapist be made at any time whether it be in individual, couples, or family sessions.

I have read and agree to the above section _____

I, _____, give my consent for treatment for myself or my child,
_____, through The Vine Wellness Group. I understand all of the above
sections that I have initialed, and agree to pay for services when received.

To be signed by client/s

Signed

Date

Signed

Date

To be signed by the therapist:

Signed

Date