STATEMENT OF UNDERSTANDING

Rebecca Davenport LCSW, PA

Welcome. This document describes my practice and the working agreement I establish with my clients. If any part is unclear, please feel free to ask for further explanation. (Revision dated 12/2004.)

4**SERVICES PROVIDED.** I offer assessment, clinical services, and appropriate follow-up. Cases that require involvement in the legal system including custody, court mandated treatment or disability cases are specialty areas that are not within the scope of my practice. As an individual practitioner, my ability to address crisis situations is very limited. Feel free to leave a message on my cell phone at any time 512-801-8353 and I will respond as soon as possible. In cases of medical or psychiatric emergency call 911 for life threatening situations. In Austin, call 472-HELP (472-4357) for the City's Hotline to Help, or 1-800-SUICIDE.

4**CONSENT FOR CARE.** By signing this document you are giving full consent for Rebecca Davenport to evaluate and administer treatment in private practice. By virtue of the nature of counseling, benefits and outcomes of treatment can not be guaranteed. Additionally, there are risks associated with psychotherapy including but not limited to: emotional discomfort, change in behaviors, and change in relationships. There are a variety of competent practitioners and programs in the Austin area. If you are in any way concerned regarding the course treatment or progress of your work in my practice, please let me know about your concerns. My goal is to assist you in meeting your therapeutic goals, whether you work with me in my practice or through another community resource.

4**FEES & REIMBURSEMENT.** There are generally 3 ways to compensate a clinician 1) through your company's EAP where there is no out of pocket fee to you, 2) under your mental health insurance policy where you are responsible for a deductible and co-payments, 3) directly from you in a private pay capacity. While filing insurance claims is a courtesy that may be extended to you, all charges are ultimately your responsibility. All charges not covered by insurance are due at the time of services. I accept Visa and Master Card for your convenience. Barring crisis situations, it is my policy to suspend sessions if a client or insurance company falls behind in payments more than 2 sessions. If financial concerns become a barrier to treatment, please notify me immediately so that we can arrange for your continued care.

FEE SCHEDULE:

Individual, family, couple psychotherapy 50 min = $90.00
Missed appointment (15 min grace period) = $60.00
Scheduled Phone Consult (30 min) = $45.00
Seminar Presentation/hr minimum = $175.00
Group psychotherapy (75 min) = $50.00
Initial Session = $110.00

4**CONFIDENTIALITY.** The information you share in therapy is confidential. I will not release information without your written consent. There are legal exceptions and exclusions that effect confidentiality in therapeutic settings. **Please note the following: 1) THIRD PARTY PAYERS** (like your insurance company or EAP) require information regarding services you receive. In signing this document you give your consent to share information with a third party for the purpose of reimbursement. If you have concerns about information being shared with reimbursing agent, please discuss this issue with me. **2)** In situations where there is a binding directive from a **COURT OF LAW**, clinical records must be released in accordance with relevant law. **3) SAFETY.** State and Federal laws stipulate that when a person is **A)** a danger to him or herself **B)** is a danger to others or **C)** has information regarding the abuse of a child or an elderly person, the clinician is required to report to the appropriate social service agency. If reporting were necessary, my goal is to include you in the notification process. Otherwise, if you request that I contact someone on your behalf you must sign an additional "informed consent for release" form.

4**COUNSELOR'S ROLE AND CONSULTATION.** The clinicians in the Hartland Plaza office are independent mental health practitioners who have come together to share certain expenses and administrative functions. No clinician is responsible or liable for the actions or opinions of any other clinician. As your clinician I am responsible to assist you in defining and working toward therapeutic goals. This process includes an assessment of your current situation and review of pertinent historic information. Goals and progress will be reviewed periodically over the course of treatment. To facilitate quality clinical services, I may engage in clinical consultation/supervision with another licensed professional in a manner that maintains your anonymity. In addition, and with client's written consent, I occasionally present cases to a peer supervisory board the outcome of which can shared with the client system.

4**CLIENT'S ROLE.** Ultimately, you are responsible for the decisions you make, including those that effect your course of care and services your receive. You are responsible for setting and keeping appointments. It's important that you provide as much notice as possible if you must miss a scheduled appointment. If you do not attend a scheduled appointment or cancel with less than 24 hours notice, you will be charged for the missed appointment. You have the right to ask for a referral out of my practice and/or terminate treatment with me at anytime.

For your convenience this document and other practice information, resources and schedules can be accessed through my web site at www.mindfulchoices.net.

ADMINISTRATIVE ACKNOWLEDGMENT Rebecca Davenport LCSW, PA

Client Name (Please Print)**:**____

DOB: ____________________________**SSN:** ______________________________

I hereby acknowledge that I have read and received a copy of NOTICE OF PRIVACY PRACTICES. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Rebecca Davenport LCSW, CEAP at 1717 W. 6th St #345, Austin, Tx. 78676, and (512) 801-8353.

Signature Date

(12/2004)

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

I hereby acknowledge that I have read and received a copy of the STATEMENT OF UNDERSTANDING revision dated December 2004 for the practice of R. Davenport LCSW, PA. I understand the contents and expectations articulated therein and agree to work with R. Davenport under the terms of this document.

Signature Date

(12/2004)