

TREATMENT AGREEMENT

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CONFIDENTIALITY

Confidentiality means that therapists have a responsibility to safeguard information obtained during treatment. It is important that you understand that all identifying information about your assessment and treatment is kept confidential, except as noted below. In order to protect your confidentiality, you must sign a release of information before any information about you is given to another person or entity.

Should you elect to utilize health insurance (including any form of managed care) for services received, be aware that often insurance and managed care companies require information regarding diagnosis, symptoms, treatment goals, and prognosis about the insured before reimbursement will be considered. Such companies may also request a copy of your records.

It is important that you understand that the laws of the State of Texas allow exceptions to confidentiality. 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 your counselor is not required to inform you of these actions. Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly. Confidentiality does not apply to cases of potential harm to self or others. A mental health professional may disclose confidential information in legal proceedings brought by a client against a professional. Confidentiality does not apply to cases involving criminal proceedings. Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship. Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without minor's consent, of the treatment needed by or given to the minor.

USES AND DISCLOSURES OF HEALTH INFORMATION

Health information about you is used for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Identifiable health information about you may be disclosed without your authorization for several other reasons: for public health purposes, for auditing purposes, for emergencies, and as described above in the Confidentiality section. Information is also disclosed when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, you will be asked for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

THE BENEFITS AND RISKS OF COUNSELING

One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to therapy. Other possible benefits may be a better ability to cope with marital, family and other interpersonal relationships, and/or a greater understanding of personal goals and values. To allow you to make informed decisions about your counseling, your counselor wishes to make you aware of certain risks involved in 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 greatest risk of counseling is that it may not by itself resolve your concerns. Your progress will be continually assessed and you will be provided referral to other sources if that is deemed necessary and appropriate. The benefit of counseling is related to the frequency, consistency and number of sessions, your openness, and your implementation of suggestions and completion of "homework" assignments between sessions. As part of the treatment plan developed during the assessment, Dr. Jones will make recommendations for the nature of treatment as well as the frequency and number of treatment sessions.

THE BENEFITS AND RISKS OF NEUROFEEDBACK

Neurofeedback has been shown through research to be effective in the treatment of various disorders (for a bibliography of research findings, visit the ISNR.org website). Rarely there are some temporary side effects of

neurofeedback, such as headaches, nausea, or disorientation. These effects generally occur in the first few visits, if at all, and are brief in nature. Since every brain is unique in many ways, protocols may need to be adjusted from session to session in order to achieve the desired results. The beneficial effect of neurofeedback is related to the frequency, consistency and number of sessions. Generally, success of treatment requires at least two sessions per week and may require 20 sessions or more. As part of the assessment, Dr. Jones will discuss the treatment plan with you, to include the frequency and total number of sessions recommended.

COST OF SERVICE

Sessions are 45 minutes, which begin at the appointment time. The fee per counseling session is \$130.00. Your fee for counseling may be reduced based on financial need, insurance allowable, or other arrangements. The fees for neurofeedback (45 minutes per visit) are \$130 for the initial assessment, \$90 for standard treatment sessions, \$130 for Z-Score sessions, and \$700 for a Quantitative EEG. The fees for neurofeedback may be reduced based on financial need, grant funding, or other arrangements. Insurance plans rarely cover neurofeedback.

PAYMENT OF FEES

All fees for counseling and/or neurofeedback are to be paid when the service is rendered. Cash, personal checks, Visa, MasterCard, Discover, American Express, and Paypal are accepted.

USE OF INSURANCE

Most insurance plans have an annual deductible, which must be met prior to reimbursement. If you have such a deductible, this is your responsibility to pay. Some insurance plans require the insured to call prior to the first visit and obtain authorization for a specified number of visits and your counselor is not allowed to call for you. You are expected to provide this authorization information not later than your first visit. If you fail to obtain this authorization prior to your initial visit, some insurance companies reduce or decline reimbursement. In this event, you are responsible for payment. All services rendered are the financial responsibility of the client or the client's parent or guardian. You are responsible for the payment regardless of insurance coverage. By signing this consent, you are authorizing the provider of services to release information concerning your assessment and/or treatment for insurance purposes and to receive direct payment for services rendered.

EMPLOYEE ASSISTANCE PROGRAMS (EAP)

If you are seeking counseling through your EAP, it is your responsibility to call your EAP and arrange for approval and provide all required information and forms to Dr. Jones before your first counseling session. If this procedure has not be completed prior to your first session, you will be expected to pay the standard fee until your EAP reimburses Dr. Jones for your counseling.

TERMINATION OF TREATMENT

You may terminate treatment at any time. Dr. Jones may terminate treatment at any time if he determines that the services he offers are no longer what you need or that he does not have the resources to adequately treat you; in such cases Dr. Jones will provide a referral to other resources.

CANCELLATIONS

Cancellations must be made twenty-four hours in advance to avoid a charge equal to your fee.

NSF CHECKS

There will be a \$25 charge for each non-sufficient funds (NSF) check.

WRITTEN ACKNOWLEDGEMENT AND CONSENT TO TREATMENT

I have reviewed and accept this Treatment Agreement and herewith consent to treatment with Mark S. Jones, DMin, LPC, LMFT, BCN, QEEGD.

Client or Legal Representative Signature

Printed Name

Date

Client or Legal Representative Signature

Printed Name

Date