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I. Psychotherapy Overview

Psychotherapy in the broadest definition is about growth. It is about living more authentically and autonomously by removing defenses and other "survival" responses that were developed during one's life, most often in childhood. My goal of therapy is to replace these functional, yet no longer appropriate, patterns with responses that are more congruent with the individuals' present life and social environment. During the initial stages of therapy, an understanding of the process and a beginning awareness of the underlying issues take place.

During the intermediate stages of psychotherapy, the initial awareness and understanding progress to a more active status, in which old patterns begin to be replaced with more appropriate, healthy responses. Functionality increases, while negative emotional responses and behavior decreases.

A client becoming increasingly able to continue the growth process on their own designates the final stages of therapy. They in essence, and again to varying degrees, become their own therapist. The safety and support of the therapeutic medium has been replaced with an internal autonomy and authenticity, allowing them to face their own issues, and adjust their psychological course as necessary and desired.

There are certain risks associated with the counseling process that should be understood before work progresses. For instance, long-lasting psychological change often requires a significant investment of time, often longer than the client's initial perception. Clients often experience deterioration in emotional and psychological stability at different times during the therapeutic process. Relationships are often affected as a result of therapy, which is most often prevalent in family relationships, but may extend beyond into one's social and professional life.

The relationship between therapist and client is the container through which change can take place. As such, it is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. For the most part, the therapeutic relationship begins and ends in the therapy office. Although it is sometimes difficult to understand, it is a necessary requirement for the maintenance of the therapeutic environment. As such, your therapist cannot be expected to be involved in a social relationship or friendship of any kind that exists outside of the therapy room.

II. My privacy commitment to you:

Your privacy is of utmost importance to me. The information I have about you will be held to the highest level of confidentiality. I will not use or disclose your health information without your written authorization. If you do authorize me to use or disclose your health information, you may revoke your authorization in writing at any time.

Other Permitted and Required Uses and Disclosures That May Be Made <u>Without</u> Your Authorization:

- **Required By Law:** As required by law, I may use and disclose your health information.
- **Legal Proceedings:** I may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal and in certain permissible conditions in response to a subpoena, discovery request or other lawful process.

- **Abuse or Neglect:** In accordance with mandatory reporting laws, I am required to report abuse and neglect of children and abuse, neglect or exploitation of an elderly person (age 65 or older) or an adult with disabilities. Suspected Cases of Child Abuse, Abuse of the Elderly or Disabled Adults will be reported to: The Department of Family and Protective Services at 1-800-252-5400.
- **Averting a Serious Threat to Health or Safety:** I may use and disclose confidential information when necessary to prevent a serious threat to your health and safety or health and safety of another person.
  .

You have the following rights regarding health information I maintain about you:

- **Right to Inspect and Copy**: You have the right to inspect and copy your health information, such as progress notes and billing records. You must submit a written request directly to me in order to inspect and/or copy your information. If you request a copy of the information, I may charge a fee for the cost of copying, mailing or other associated supplies. I may deny your request to inspect and/or copy in certain limited circumstances. If law requires such review, I will select a mental health professional to review your request and my denial.
- **Right to Amend**: If you believe information I have about you is incorrect or incomplete; you may ask me to amend the information. You have the right to request an amendment as long as the information is kept in this office.
- **Right to request restrictions**: You have the right to request a restriction or limitation on the confidential information I use or disclose about you for any of the purposes outlined above. You also have the right to request a limit on the information I I disclose about you. I am not required to agree on such requests.
- **Right to Request Confidential Communication**: You have the right to request that I communicate with you about treatment matters in a certain way or a certain location.

III. Therapist Credentials

Education
Elizabeth Stanfield, M.Ed., L.P.C. (license number 62534), has graduated with a Master of Education in Counseling Psychology from the University of Texas at Austin. She began her counseling career at Capital Area Mental Health Center and since 2007 has been in private practice. She has a special certification and training in sex addiction and is a Certified Sex Addiction Therapist, training under Dr. Patrick Carnes.

Betsy received her undergraduate degree in Finance from Villanova University and her Masters in Business Administration from University of Texas at Austin. She had a finance and marketing career in NYC and Austin, TX.

Texas State Board of Examiners of Professional Counselors: - To report any concerns:
1100 West 49th St., Austin, TX 78756-3183 512-834-6658

IV. Appointment Scheduling/Cancellation/Length

The primary service I offer is weekly psychotherapy, which promotes faster healing and process; therefore, making it important to attend consistently. Clients are expected to attend all scheduled sessions, which will start and end in a timely manner. **I require 48 hours notice of any cancellation and will charge the full fee for missed appointments without proper notice.** I have a waiting list and failure to cancel an appointment may result in others not receiving the help they need and want. Please let me know if you need help remembering your appointment.

I usually schedule one 50-minute session per week for both individuals and/or couples. Appointments for a crisis are often intensive and may involve longer and/or more frequent sessions. By prior arrangement, sessions may vary in length or frequency. When appropriate, we will work out a regularly scheduled appointment as one becomes available. Your collaboration in being punctual for starting and ending sessions at the appointed times will be appreciated.

V. Fee/Payment

Fees will be agreed upon at the time of scheduling and payments are due at the beginning of each session.
A $30.00 service charge will be charged for each check that is returned. I also charge on a pro-rata basis for any other professional services you may need such as report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other services you may request of me. If you become involved in legal proceedings that require my participation, I expect you to pay for my professional time even if I am called to testify by another party.

I do not bill insurance companies for you and do not accept insurance deductibles and co-payments. You are responsible for payment of all fees even if you plan to seek insurance reimbursement. As a service to you, I will provide you with a billing statement that you can provide to your insurance companies and other third-party payers; but I will not provide paper work requested by insurance companies, treatment codes, or reports regarding your history or treatment without your authorization.

VI. After Hours Policy/Procedure

If you need to contact me at any time, you may do so by leaving a message on my confidential voice mailbox at 512-743-7080. I will make every effort to return your call that same day.

If you are in crisis, please call the 24-hour crisis hotline at 472-HELP(4357).

I may not be available to respond to emergency situations and will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs. Therefore, if you need immediate assistance, again - please contact the hotline at 472-4357 or 9-1-1 for help.

Acknowledgement of Receipt of Informed Consent

I hereby acknowledge that I received a copy of this notice.
(If you are under 18 years old please sign below and have parents sign too.)

Printed Name: ____ Date: _______________

Client Signature: ____

INTAKE FORM

Name ______________________________ Date ____________________

Street Address ____

City ____________________ State ______ Zip Code ____________________

Mailing address (if different from above)___________________________________

Telephone: Cell ______________________ Home _____________________

E-mail address ____

Male ____ Female ____ Date of Birth ________________ Age __________

Highest level of education _________________ Referred by ___________________

Occupation ____

Relationship status __________________ Years in current relationship ___________

Spouse/partner name ______________________ Age ____ Occupation ___________

Prior Marriages/Long Term Partnerships (Duration/End Date)_____________________

____

Children (names, ages) ____

Siblings (names, ages) ____

Parents or step-parents (Ages or year of death) ________________________________

____

Person to call in emergency (1) _______________________ Phone ______________

Reason you decided to enter therapy ______________________________________

____

____

____

____

Medical doctor ________________________ Phone ______________________

Current medications ____

Past and present medical care (specify major problems, accidents, hospitalizations)
____
____
____

<u>Past and present counseling or psychotherapy</u>:

Check here if none _______

1. Psychotherapist name _________________________________ Dates: ________ to ________

   Reason for seeking therapy ____

   Outcome ____

2. Psychotherapist name _________________________________ Dates: ________ to ________

   Reason for seeking therapy ____

   Outcome ____

Have you ever been hospitalized for psychiatric reasons? _______

If yes, please describe, including dates ____
____
____

Past or present drug or alcohol use? ____
____

Do you have a family history of alcoholism, depression, anxiety, mental illness, violence, or suicide? ____
____
____

Have you experienced traumatic events in your life? If so, please describe and give approximate dates ____
____
____

Current living situation ____

What causes you stress? ____
____
____

How would you describe your social support network? ______________________________
____
____
____