

ELIZABETH STANFIELD

M.Ed., MBA, LPC, CSAT

3445 Executive Center Drive, Building 3, Suite 103

Austin, TX 78731

(512) 743-7080

BetsyStanfieldLPC@gmail.com

Counselingaustintx.com

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.

The ultimate goal of psychotherapy is to facilitate positive change in clients seeking enhanced emotional and social functioning as well as higher satisfaction in the overall quality of their lives. I want to help my clients live happier, healthier and more productive lives.

II. Privacy commitment and health information protection:

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 information, you may revoke authorization in writing at any time.

Other Permitted and Required Uses and Disclosures That May Be Made Without 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.
- **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.

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

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.

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

Basic 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.

Legal Fees: 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. **Fees are due at time of request.**

- Client Records Provided to Attorneys: \$1,500: An additional fee of \$500 is required for expedited requests of less than 10 days.
- Depositions: \$1,500: Requests made less than 3 weeks in advance incur an additional \$500 fee, less than 2 weeks in advance an additional \$1,000 fee and less than 1 week in advance an additional \$1,500 fee to account for the disruption to my schedule.
- Court Appearances - \$3,000: Must be scheduled at least 3 weeks in advance. Payment is due when scheduled and is non-refundable. Requests made less than 3 weeks in advance incur an additional \$1,500 fee, less than 2 weeks in advance an additional \$2,000 fee and less than 1 week in advance an additional \$2,500 fee to account for disruption to my schedule.

Insurance: 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 _____

Gender _____ 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)

Past and present counseling or psychotherapy:

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? _____
