INFORMED CONSENT

Substance abuse assessment and substance abuse counseling

Jim Savage, LCDC
5301 Village Creek Dr
Suite A
Plano, Texas 75093

Qualifications:

Jim Savage, LCDC is licensed by the Texas State Department Of Health Services. License #3353

AVAILABLE SERVICES: Jim Savage, LCDC provides counseling services related solely to substance abuse issues. These services may include assessment, individual, family and group therapy. Substance abuse issues impact those whose lives touch the substance abuser, therefore services may often be provided for individuals other than the substance abuser.

COUNSELING PHILOSPHY: Jim Savage, LCDC provides substance abuse counseling services for adults, adolescents, and family members impacted by alcoholism and drug addiction. In many cases, following as initial assessment, recommendation may be given to pursue treatment through another provider. In this event, you will be provided with referrals and assisted in the process.

Counseling and therapy are beneficial, but as with any treatment, there are inherent risks. Assessment and subsequent counseling will involve discussion about personal issues and may bring to the surface uncomfortable emotions for any or all of the individuals involved. The goal of the counselor is to follow the path of truth, however uncomfortable or painful that may be at times. With substance abuse counseling there are frequently specific recommendations indicated that could involve significant lifestyle changes that the client may not want, or agree with; this may be construed as a “risk” associated with treatment. However, the benefits of assessment and counseling can far outweigh the risks. Some of the benefits include improved personal and family relationships, reduced feelings of emotional distress, improved personal performance, reduction of health and safety dangers, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire to work with you to attain your personal goals, which may include obtaining the right help for a client who may be resistant to the treatment process.

The goal of Jim Savage, LCDC is to provide the most therapeutic experience available to you. If at any time you feel that you and your counselor are not a good fit, please feel free to discuss this matter to determine if transferring to a more suitable counselor is right for you. If you and your therapist decide other services would be more appropriate, we will assist in finding a provider to meet your needs.

CLIENT/THERAPIST RELATIONSHIP: You and your counselor have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your counselor can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

APPOINTMENTS Regular counseling sessions are approximately 50 minutes long. Adolescent assessments are scheduled for 90 minutes, but 2 hours are blocked out on the calendar to ensure proper amount of time to complete session adequately.

Extended sessions may be scheduled for conjoint session with parents and child and/or other family members.

FEE SCHEDULE:

Regular office visit (50 min.)	$ 125.00
Adolescent assessment and recommendation (intervention) (90-120 min.)	$ 185.00
Extended sessions (90 min.)	$ 185.00
Written reports (probation, judge, school, Employers, attorneys, etc)	$ 100.00
Returned check fee per check	$ 30.00

CANCELLATIONS: Appointments not cancelled 24 hours prior to scheduled time will be charged the regular rate of scheduled session.

PAYMENT/INSURANCE FILING Payment of fee is expected at the time of each appointment. You may pay by cash, check, or credit card. Jim savage, LCDC does not accept insurance, however if requested, receipts and documentation for submission to your insurance company will be provided.

The counselor reserves the right to suspend or discontinue service in the event of an unpaid balance.

CONFIDENTIALITY: All communication between you and your therapist becomes a part of the clinical record. This record is accessible to you at your written request. Your therapist will keep confidential all conversations with regards to the following exceptions: a) you authorize your therapist to disclose information to a particular party; b) your therapist determines that you are a threat to yourself or to others; c) you disclose that harm has been done to a child; d) the court has ordered information to be disclosed. Client records are disposed of seven years after the file is closed. Minor client's files are disposed of seven years after their 18th birthday.

CLIENT RIGHTS: You have the right to refuse or modify any therapeutic technique or direction that you feel may not best serve your needs. You have the right to discuss positive and negative effects of counseling with me. You have the right to be treated in a professional and ethical manner. If you are dissatisfied for any reason, please discuss your concerns with your counselor. If you feel your are unable to resolve an issue, or that your counselor has performed in an unethical manner, you may report your complaint to:

Texas Department Of State Health Services
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

TERMINATING TREATMENT: You have the right to terminate or take a break from your treatment at any time without the counselor's permission or agreement. However, if you do decide to exercise this option, you are encouraged you to talk with your counselor about the reason for your decision in a counseling session so that sufficient closure can be achieved. During the final session appropriate referrals can be made.

By your signature below you are indicating that you have read and understand this agreement and that you are willing to undergo substance abuse assessment and/or ongoing counseling with the undersigned therapist.

_____	_____	_____
Client/parent signature	Printed name	Date

_____	_____	_____
Client (if minor) signature	Printed name	Date

_____	_____	_____
Therapist signature	Printed name	Date