Donald C. Mappes, Ph.D., LPC, LMFT
2363 Highway 287 North, Suite 101
Phone: (817) 265-8888 **Mansfield, TX 76063-7599** **Fax: (817) 886-2613**

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and Dr. Mappes 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. Dr. Mappes 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.

AVAILABLE SERVICES: Dr. Mappes offers a wide array of counseling services, including individual, couple and family services. I agree that relationship and (premarital) counseling begins with an individual intake evaluation of each person to screen for anything that might sabotage the relationship goals. **Initial here**:_____

Dr. Mappes is licensed by the Texas State Board of Examiners of Licensed Professional Counselors and Texas State Board of Examiners of Marriage and Family Therapists. Effective counseling is founded on mutual understanding and good rapport between client and therapist. It is my intent to convey the policies and procedures used in my practice, and I am pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for coaching, counseling and/or psychotherapy.

COUNSELING: I provide short-term counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which you and I will determine your concerns, and if we both agree that I can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided, services to you may be terminated.

It is my goal to provide the most effective therapeutic experience available to you. If at any time you feel that you and I are not a good fit, please discuss this matter with me to determine if transferring to a more suitable Therapist is right for you. If you and I decide that other services would be more appropriate, I shall assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide my clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

I think of myself as a coach. The coach does not get on the field with the team, but from the sideline gets a clearer view of what is happening when the ball is in motion than many of the team members do. The coach has conversations with the team and may suggest various exercises to practice, both of which support the team in winning.

If you become uncomfortable or uneasy with what I say or how I express myself in our sessions, it is important that you tell me so. I need such feedback to be able to adjust my approach to best serve you.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if appropriate. Please call my main number (817) 265-8888 to reschedule or cancel appointments, calls made to other numbers will not work. If I do not receive such advance notice, you will be responsible for paying a No-Show/Late-Cancellation fee of $60.00, unless prohibited by contractual agreement. Failure to receive an appointment reminder call the day before the session, does not negate the no show fee. Insurance and other third party payers cannot be asked to pay fees for missed appointments. If I ever miss an appointment, I will provide you one session at no charge. This will free your appointment time for another client.

Inclement weather cancellations: This office will be closed on any days that the Arlington Independent School District (AISD) closes schools due to bad weather.

FEE SCHEDULE:Diagnostic & Evaluation Session (1st visit)	$150.00
Regular Office Visits (50 minutes) (Individuals, Couples & Family)	$100.00
Family Sessions (50 minutes)	$100.00
Outside Office Work (inpatient visits, consultation, collaborative law services	$150.00
Forensic work (court testimony)per hour plus travel and expenses)	$500.00
Written Reports (insurance companies, supervisors, etc. pro-rated per hour	$100.00
Returned check fee per check	$ 50.00
Missed appointments/Late Cancellations	$ 60.00
Records copy $0.50/page & $25.00 search/locate fee (includes 1st 10 pages	

Emergency telephone consultations are $1.00 per minute 10:00am to 7:00pm and $4.00 per minute 7:00pm to 10:00am and weekends and holidays, with a five-minute minimum. Emergency telephone consultation fees are not covered by insurance.

The completion of any forms and letters written on behalf of clients, outside of the regular session time, will be billed at the rate of $100 per hour. Insurance companies rarely reimburse for the completion of their forms or special letters, even when required to obtain disability or other insurance benefits.

A reasonable fee will be charged for copies of any records requested by the Client. Cash, personal checks, Discover/Novus, MasterCard & VISA are acceptable for payment. Fees for managed care clients are at the contracted rate.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Dr. Mappes or a professional insurance billing service will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact my office regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, you can call my main number (817)265-8888 and press 2 to be connected to my cell phone. Please utilize this method *only in the event of a serious crisis*, and I will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When Dr. Mappes is out of town, you will be advised and given the name of an on-call Therapist.

(Over Please → → →)

Childcare, etc: Young children may not be left unattended in the reception room or building. Office staff does not provide childcare services. Childcare is available by the hour at several convenient locations. Please ask for directions. Personal items left in the office will be disposed of 90 days after last contact or being informed of the left item.

Complaints: If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at (512) 459-2900, the Texas State Board of Examiners of Marriage and Family Therapists at (512) 834-6657, or the National Board for Certified Counselors in Greensboro, NC, at (910) 547-0607.

CONFIDENTIALITY: Dr. Mappes follows all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of Dr. Mappes when you and he discuss this matter further. By signing this Information and Consent Form, you are giving consent to Dr. Mappes to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless Dr. Mappes from any departure from your right of confidentiality that may result.

E-mails are not confidential, unless they are encrypted. Please do not E-mail me. Text messages are not confidential. Please do not text me. I agree if I text message or e-mail Dr. Mappes, I release and absolve him from any liability for the breach of confidentiality my actions may cause. **Initial here**:_____

DUTY TO WARN/DUTY TO PROTECT: If Dr. Mappes believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Dr. Mappes to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to Dr. Mappes to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
_____	_____
_____	_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of Dr. Mappes, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by Dr. Mappes, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form (please sign both copies, keep one for your files and return the other copy to me) as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Dr. Mappes will not render services to your child until he has received and reviewed a copy of the most recent applicable court order.

_____	_____
Signature – Client/Parent	Date
_____	_____
Signature – Spouse/Partner/Parent	Date
_____	_____
Therapist	Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____	_____
Client/Parent	Date

I authorize the payment of medical benefits to the provider of services.

_____	_____
Client/Parent	Date