David Ashburner, MA, LPC, NCC, CSAT, CMAT, CHFP
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Informed Consent Agreement

This document contains important information about counseling, my business policies, and me. Please read it carefully and note any questions you might have so that we can discuss them. Once you sign this form, it will constitute an agreement between us.

The following is an agreement entered into between **David Ashburner, MA, LPC, CSAT, CMAT, CHFP**, the therapist, and (print) _____ as client(s), on _____ (date).

Counseling Approach: My method of counseling combines cognitive-behavioral therapy, family-systems therapy, solution-focused therapy, task-centered therapy, and group therapy, as well as other approaches that may fit a given client or couple. I take a positive approach to problems, assuming that people are resilient and have tremendous abilities to address their life situations. It is my role as a counselor to help you understand the dynamics of your situation and to help you use your particular strengths to address your issues.

Qualifications: I am a Licensed Professional Counselor (LPC) and National Certified Counselor (NCC), along with being a Certified Sex Addiction Therapist (CSAT), and Certified Multiple Addiction Therapist (CMAT), through The International Institute of Trauma and Addiction Professionals (IITAP). Also, I have gone through rigorous one-on-one training to be a Certified Hope and Freedom Practioner (CHFP). I am a member of The Society for the Advancement of Sexual Health (SASH), formerly known as the National Counsel on Sex Addiction and Compulsivity, and the American Counseling Association (ACA).

I have earned the following degrees:

- Master of Arts in Professional Counseling, Argosy University Dallas
- BS in Pharmacy, St. Louis College of Pharmacy
- BS in General Studies, Southeast Missouri State University

Therapeutic Relationship: Our contact will be limited to psychotherapy sessions that you arrange through me. If I see you in public, I will protect your confidentiality by acknowledging you *only* if you approach me first. Office clerical personnel will only have enough information about you to schedule appointments, contact you, and facilitate collection of fees. It is my policy not to accept gifts from clients of more than a nominal value.

Any type of audio/video recording is prohibited in the counseling session, unless expressly agreed to in writing between the therapist and the client. In all cases, the audio/video recording is part of the clinical record, and the property of the therapist.

Benefits and Risks of Treatment: Symptoms may worsen before they get better because psychotherapy may bring up unpleasant memories and emotions. I will facilitate your journey, supporting you as you move forward; however, *you* are the one who must do the work to get the results you desire. Your willingness to work hard and make a commitment to the therapeutic process is necessary for you to achieve and maintain the long-term results you want. The benefits of outpatient psychotherapy may include improved functioning in your personal and professional relationships, improved communication skills and a reduction in symptoms that led you to seek therapy in the first place.

Client's Initials_____ 

Client Rights and Responsibilities: You may end our therapy relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my psychotherapy techniques or suggestions that you believe might be harmful. You agree to come to therapy free from the influences of drugs, including alcohol.

Referrals: Should you and/or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

No Emergency Calls: This office *does not* take emergency calls. If you have an emergency, go to your nearest hospital emergency room or call 911.

Fees and Agreement: The fee for therapy is $150 per 60-minute session, and $200 per 90-minute session.

You will be billed in full for missed sessions unless you call 214-773-6201, at least 24 hours in advance, to cancel the appointment. The following credit card information will be used only for this purpose.

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express

Name as it appears on the card: _____

Credit Card Number: _____

Security Number (last 3 digits on the back): _____

Expiration Date: _____

Billing address:

Street _____ City_____ State _____ Zip_____

Client's Initials_____

Miscellaneous Fees: There is a $250 flat-rate charge for each letter clients request being sent on their behalf. Court appearance and/ or testimony is provided at a flat-rate of $3,500 per day, with the minimum charge being $3,500. In the event the therapist is required to be present at the court for additional days waiting for his testimony to be given, each day of waiting is charged at the same $3,500 flat-rate. Travel time is figured at the same rate as above. There is no charge for travel time for testimony given in the Texas counties of Dallas, Tarrant, Collin, Denton, or Rockwall, or within a radius of 50 miles of the city of Plano, TX. All travel outside these areas are charged a minimum of 1⁄2 day ($1,750) for travel to court and a minimum of 1⁄2 day ($1,750) for travel from the court back to Plano. Expenses such as hotel, taxi, meals, etc. are the responsibility of the client and are in addition to the daily charges delineated above.

Unpaid Debts/Returned Checks: *Payment is required when services are rendered*. Unpaid debts will be turned over to a collection agency. Collection fees will be added to the client(s) bill. Returned check (i.e., insufficient funds, etc.) charge is $30.

Insurance Waiver and Agreement: This office *does not* file insurance claims but a receipt will be provided. The client(s) understand that they are responsible to obtain any pre-certification for Intensives without the assistance of their therapist. The client(s) understand that verification of benefits or pre-certification of services does not guarantee that an insurance carrier will cover this type of outpatient intensive service, and the client agrees to pay at the time of service.

Client's Initials_____

Records and Confidentiality: All of our communication becomes part of the clinical record. Records are the property of the therapist. By law and professional ethics, your sessions are strictly confidential. Generally, no information will be shared with anyone without your written permission. If you have seen another therapist or health care professional it may be helpful for me to share information with them. If this is necessary, I will ask for your written permission to contact them.

Also by law and professional ethics, here are several exceptions to this confidentiality policy:

a) I determine that you are a danger to yourself or someone else
b) You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person
c) You disclose sexual contact with another mental health services provider
d) I am ordered by the court to disclose information
e) If there is a licensure board inquiry, I may be required to share information with the board
f) If action is required to collect fees, then confidentiality may be breached through collection procedures
g) I am otherwise required by law to disclose information

In the case of couples or family psychotherapy, I will keep confidential (within the limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to therapeutic progress.

Client's Initials_____ 

Acknowledgment and Consent: By your signature(s) below, you are indicating that you have read and understand this statement, that you have had an opportunity to ask questions, that any questions you have about this statement have been answered to your satisfaction, and that you were furnished a copy of this statement.

By my/our signature(s), I/we agree to the terms and conditions outlined within this document. (Each participant is required to sign this agreement form.)

Client Name (Print) _____

Client Signature _____ Date _____

Client Name (Print) _____

Client Signature _____ Date _____