Center for Marriage & Family Counseling
8380 Warren Parkway #604
Frisco, TX 75034
(972) 277-1217
Terri Burns, MA, LMFT

Terri Burns, MA, LMFT is a Licensed Marriage and Family Therapist with over 3 years serving couples and families through their challenges.

Confidentiality: We are committed to confidentiality to the fullest extent allowed by Texas law. You should also know that there are certain situations in which we are required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, we are not required to inform you of my actions in this regard. These situations include but are not limited to the following: (a) If you threaten bodily harm or death to yourself or another person; (b) If a court of law issues a legitimate court order (signed by a judge), we are required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse (past or present), I am required by law to report this to the appropriate authority; (d) If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed of the court; (e) Any sexual improprieties by a former therapist must be reported to the AAMFT Ethics Committee, and (f) If you are seeking payment through an insurance company, we will be required to reveal confidential information to them (each insurer is different). The ethical code of marriage and family therapy prohibits dual relationships between clinician and patient and former patients. This means as our client we cannot meet with you for social occasions or be involved in any business activities with you other than providing psychotherapeutic services.

Risk to Treatment: The goals of therapy are to provide information, emotional support, and skills to improve personal effectiveness, preserve personal safety, and to develop problem solving strategies to deal with current problems. Psychotherapy has both benefits and risks. Psychotherapy has been shown to produce significant improvements in emotional well-being, family and personal relationships, and work and school performance. Risks include experiencing uncomfortable levels of feelings like frustration, sadness, guilt, and loneliness. Although therapy can be a powerful life changing process, there are no guarantees about what will happen. Therapy has a natural process to it, which includes a beginning (getting acquainted, identifying problems, setting goals), a middle (treatment activities-exploring approaches, developing solutions), and an ending (evaluation of goal attainment, after care goals, closure activities). We hope that you will see therapy through all these phases.

Emergency Contact/ Duty to Warn: If the undersigned therapist reasonably believes that I am a danger, physically or emotionally to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name Telephone Number

_____

I consent for the undersigned therapist to communicate with me by mail and by phone at the following addresses and phone numbers, and I will IMMEDIATELY advise the therapist in the event of any change:

Address Telephone Number

_____

Appointments & Missed Appointment Policy:

Appointments: All sessions are scheduled by appointment only. Appointment times are based upon the current fee schedule.

Set Repeated Appointments: Sometimes setting up a set weekly or biweekly appointment time is the best way to ensure that you will be able to get an appointment time or one that best fits your schedule. However, if you make this kind of appointment, you are committed to that time until you specifically state you would like to give it up. If two set appointments are missed, we will only be able to schedule with you on a week-to-week basis to open space for clients that need set appointment times.

Missed Appointments: Appointments canceled with 24-hour notice incur no fees and every effort will be made to reschedule in a timely manner. If you are unable to keep a scheduled appointment, please contact the office at **972.277.1217** at least 48 hours in advance

._____(initial.) Appointments missed or canceled with less than 24-hour notice will be charged a $130.00 cancellation fee.

_____(initial.) I understand that emergencies and health problems do come up and we are willing to consider them when adequate (at least 24 hours) notice is given.

However, late notice of sickness, No-shows, last minute scheduling conflicts with other professionals, sports events, family events, generally will not be considered. Please note that the provider may terminate the counseling relationship after 2 missed appointments without calling to cancel 24 hours prior to your scheduled appointment. Additionally, any balance on the account for missed appointments must be paid prior to rescheduling an appointment.

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Legal Proceedings: If you are currently involved or become involved with any legal proceedings, please inform your therapist as soon as possible. It is important that we discuss how the proceedings might impact your work together. If legal actions occur in which you will be responsible to pay your therapist AND her attorneys, as well as the CMFC site supervisor attorney's fees involved for the following even if the subpoena is sent from the opposing side of the case; (a) the time spent for travel to/from court at the rate of $200.00 per hour per therapist; (b) the time spent on preparing testimony, reports, witness time, and depositions at the rate of $200.00 per hour per therapist; (c)the time spent on court appearances are billed at $1,500 per half-day and $3,000 per full-day per therapist. Subpoenas must be sent to both your therapist and the CFMC Site Supervisor.

Communication:
I do not have staff answering the phones, so please call my cell phone at **972.277.1217.**
Telephone Communication: If we are available, we will respond by cell phone after hours and between sessions for non - emergencies for up to 10 minutes w/o charge. That number will also accept confidential voicemail messages. Phone calls over 15 minutes in length will be billed at agreed upon hourly rate prorated to the minute. Please note that telephone calls after 5:00 pm will not be returned until the next business day. If you find yourself facing an emergency, please contact emergency services (911) immediately or go to your nearest hospital emergency room.

Text Messaging: This form of communication cannot ensure confidentiality and should not be used. Electronic Communication: When we are available, we will respond to email communication. However, we cannot ensure confidentiality of any correspondence sent via email and cannot be responsible for breaches in confidentiality resulting from someone getting your password or having access to your account. Therefore, email communication should be reserved merely for scheduling and/or canceling appointments. Additionally, all email correspondence between us will be printed and placed in your file. The email is terri2burns@gmail.com.

Records and Administrative Services: If you request it, a summary of your clinical services can be released to a person or agency you designate. There is a $50 fee to write a written summary of your clinical services. Payment in the amount of $200 per hour will be charged for administrative services beyond the scope of 30 minutes to write a clinical summary. These services include but are not limited to: (a) consultation with other professionals, (b) preparation of reports or correspondence, (c) phone calls lasting over 10 minutes.

Discussion of Treatment Plan: Within a reasonable period after the initiation of treatment **Terri Burns LMFT** will discuss with you (client) his working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used during your therapy, their possible risks, **Terri Burns LMFT** expertise in employing them or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that **Terri Burns LMFT** does not provide, she has an ethical obligation to assist you in obtaining those treatments.

No secrets" policy with couples or families
_____ initial This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see or speak separately with a smaller part of the treatment unit (e.g., an individual or two siblings). These discussions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such discussions with me, please understand that these discussions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those discussions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual discussion (or a discussion with only a portion of the treatment unit being present) with the entire treatment unit – that is the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you may want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual discussion may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the

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need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

Dual Relationships: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs objectivity, clinical judgment or therapeutic effectiveness or can be exploitative in nature. **Terri Burns LMFT** will carefully assess before entering into non-sexual and non-exploitative dual relationships with clients. North Texas is a small area and many clients know each other and **Terri Burns LMFT in the community.**

Consequently, you may encounter someone you know in the waiting room or may encounter **Terri Burns LMFT** in the community. **Terri Burns LMFT** will never acknowledge working with anyone without her written permission. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it, and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to **Terri Burns LMFT** if the dual relationship becomes uncomfortable for you in any way. **Terri Burns LMFT** will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if s/he finds it interfering with the effectiveness of the therapy or the welfare of the client, and of course you can do the same at any time.

Discontinuing Treatment/Complaints: It is also important to understand that you are free to discontinue treatment at any time and agree to notify us immediately so that we may provide you with referrals for continued care. If at any time you wish to file a formal complaint regarding my counseling services, please contact the Texas State Board of Examiners of Professional Counselors and/or Texas State Board of Examiners of Marriage and Family Therapists, Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369; 1-800-942-5540. Additionally, we have the right to terminate your treatment at any time. Some of the reasons include but are not limited to boundary violations, noncompliance with treatment, failing to follow appointment policies and procedures, and non-payment of fees and/or services rendered. Should your therapist decide to discontinue treatment, you will be provided a referral source for another psychotherapy professional or agency.

If you request it and authorize it in writing, Terri Burns LMFT will talk to the psychotherapist of your choice to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, Terri Burns LMFT will assist you in finding someone qualified, and if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, Terri Burns LMFT will offer to provide you with names of other qualified professionals whose services you might prefer.

Good Faith Estimate:. The good faith estimate is the costs of the services provided by Terri Burns, LMFT. If you are billing your insurance, it is considered out-of-network. This is to clarify the "No Surprises Act" recently passed by the Department of Health and Human Services requiring these fees be implemented to ensure high quality services and uniform charges. Clients/guardians are responsible for payment and for all services rendered. Payment is due at the end of each session. Payment is estimated for a weekly, biweekly, and monthly schedule.

Records and Administrative Services: If you request it, any part of your recordin the files can be released to any person or agency you designate. These requests must be made in writing and allow 30 days to process. There is a 50 fee to obtain a copy of your client record. Payment in the amount of 200.00 an hour will be charged for administrative services beyond the scope of the therapy sessions with the minimun of 30 minutes to complete a service. These services include but are not limited to : a) consultation with other professionals b) preparation of reports or correspondence, c) phone calls lasting over 10 minutes.

I understand that I am responsible for payment for services provided. I understand that I am responsible for submitting claims to my insurance company should I wish to be reimbursed. I understand that I am giving up some of my consumer billing protections under the federal law. I understand that I may get a bill for the full charges for these items and services or have to pay out-of -network-cost-sharing under my health plan. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.

The amount of treatment required vaires on diagnosis and length of symptoms. Some treatment requires longer than a year and some require less. Therefore, I cannot calculate the length of treatment. This is a list of anticipated **annual** fees based on the services I provide. This does not include no shows/late fees, after hours fees, bank charges, court/litigation fees, or non-therapuetic charges.

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Annual estimated costs

150.00 (a session for couples and families) *50 sessions is equals 7,500.00

130.00 (a session for individuals)*50 sessions equals 7, 000.00

Consent to Treatment:
1. I agree to enter therapy with the Center for Marriage & Family Counseling. I understand that if I am seeing Terri Burns who is an LMFT.

2. I have received a fee schedule and I agree to pay for services rendered with payment due at the conclusion of each session and no balance will be carried. Terri Burns is not on insurance panels and I will pay for services at time of services and can receive reimbursement from my insurance by providing a receipt for services rendered.

3. I understand that I can leave therapy at any time, and I have no moral, legal, or financial obligation to complete the maximum number of sessions listed in this contract; I am contracting only to pay for completed therapy sessions. 4. A 24 hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay the **$130 No-Show Fee**. I understand that this will be my responsibility for missed appointments.

Authorization for Credit Card Use

All information will remain confidential

Name on Card: _____

Billing Address: _____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx_____

Credit Card Number: _____

Expiration Date: _____
Card Identification Number: _____ (last 3 digits located on the back of the credit card)
Amount to Charge: $ _____ (USD)
I authorize _____ to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Signature: _____
Date: _____
Print Name: _____

5. If I miss an appointment without prior notice and do not contact this office within 10 business days following the missed appointment, then I understand my therapy will have terminated.
6. I understand that the therapist has the right to see legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist has the right to use confidential information to establish the fee claim.
7. You acknowledge that you have received and understand the Notice of Privacy Practices for this

office.

Signed: _____ Date: _____

IF A CLIENT IS A MINOR: I give permission for this minor child(ren) to receive counseling without a parent or guardian present. I have the legal authority to seek and grant permission for professional services for a minor child, there being no legal decree disallowing my authority to assume such responsibility.

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Name of Child: _____DOB: _____

Name of Child: _____DOB: _____

Name of Parent or Legal Guardian: _____

Signed: _____ Date: _____

2023 Fees and Payment:

Clients or Parents/Guardians are responsible for payment for all services rendered. Payment or Co-Payment is due by the end of each session. Payment may be made with cash or credit card. A completed receipt will be provided at the end of each session documenting the service delivered and fees paid. Please also be aware that there is a $50 fee for any credit card charge backs/declines. Except where we have a contractual agreement with a Third Party Payor, our fees are as follows:

Diagnostic Evaluation/ Initial Consultation $150.00
Individual Psychotherapy (30 Minutes) $60.00
Individual Psychotherapy (45-50 Minutes) $130.00
Couples and Families (45-50 Minutes) $150.00
Group Psychotherapy (60 Minutes) $60.00

- Virtual Video or Telephone Psychotherapy is same rates as above
- Your clinician can visit with ways to make counseling affordable $_(agreed upon rate)

Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. Upon request, Terri Burns will provide you with a copy of your receipt for counseling services provided on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. Not all issues/conditions/problems dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your out-of-network mental health benefitsts.

NOTICE OF PRIVACY PRACTICES
Center for Marriage & Family Counseling

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
CMFC is required by law to abide by the terms of this Notice of Privacy Practices, allow you to review this Notice prior to granting consent, and notify you of changes/revisions to this Notice. If you believe your privacy rights have been violated, you may submit a written complaint to CMFC or to the Secretary of Health and Human Services describing in detail the way you feel your privacy rights have been violated. The Center for Marriage & Family Counseling will not retaliate against you in any way for filing a complaint, or with the Secretary of State.

YOUR PRIVATE HEALTH INFORMATION (PHI)
Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral, or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment, and future care. Your healthcare record is the physical property of the Center for Marriage & Family Counseling, but you have certain rights to restrict some of the uses or disclosures of the information contained in your healthcare record. Center for Marriage & Family Counseling: however, has the right to use and disclose the information contained in your healthcare record in the process of providing treatment, receiving payment, and performing other regular health operations such as:

- Documenting and describing the care you received for legal purposes
- Communicating with other healthcare providers who may be involved in your case
- Educating health care professionals
- Evaluating and improving the care you receive, and the outcomes achieved
- Billing and verification of services provided to you

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of CMFC. Center for Marriage & Family Counseling is required by law to maintain privacy and confidentiality of your health information, provide you with this Notice of Privacy Practices, notify you of your rights to restrict use of this information, notify you if CMFC. is unable to agree to a requested restriction and allow you to review the Notice of Privacy

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Practices prior to granting consent and notifying you of changes/revisions to this Notice. Examples of disclosure of your PHI and your rights concerning PHI are continued below. If you have questions or would like additional information, contact Shane Adamson the privacy officer for CMFC at 214-250-7808.

Mediation & Arbitration: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of CMFC Director and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Collin County, TX in accordance with the rules ofthe American Arbitration Association which is in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, clinic director Shane Adamson can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum and attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

NOTICE OF RECEIPT AND ACKNOWLEDGMENT OF POLICIES

Client Name: _____

DOB: _____

Client Name: _____

DOB: _____

_____ Notice of Privacy Practices
(initial)

_____ No Secrets Policy
(initial)

_____ Good Faith Estimate
(initial)

_____ Informed Consent Policies
(initial)

Signature of Client _____ Date _____

Signature of Client_____Date_____

Signature of Parent, Guardian, or Personal Representative _____ Date_____

Clinician Signature – Terri Burns LMFT Date _____