RIDGLEA FAMILY GUIDANCE

3509 Hulen Street, Suite 207
Fort Worth, TX 76107
817-731-3700

Welcome Letter

Welcome to Ridglea Family Guidance. I look forward to meeting you and helping you achieve what you want in your life. My name is Cheryl Dielman and I am trained in many different specialties that I tailor to your unique needs. However, the therapeutic system I use most often is Internal Family Systems (IFS). Many of my clients have told me that they have appreciated learning how to make sense of the conflicting feelings and thoughts that create so much stress on a daily basis. Many report feeling lighter inside, and that decisions are easier to make when they are able to respond from accessing a calm, centered place inside themselves. And in turn, many clients have found that they appreciate what their feelings can teach them.
Please fill out the attached paperwork and return it at no later than 72 hours/3 business days prior to your initial appointment.
Feel free to contact me with any questions or concerns you may have.

Warmest Regards,
Cheryl Dielman, LCSW-S, LPC-S, CEDS-S
Ridglea Family Guidance
3509 Hulen St., Suite 207
Fort Worth, TX 76107
Phone: 817-731-3700
Fax: 817-731-9547

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PROFESSIONAL DISCLOSURE STATEMENT

Cheryl Dielman, LCSW-S, LPC-S, LMFT, CEDS

My Education includes degrees in Psychology and Social Work. I am a Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT). I am also an approved supervisor for: Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage & Family Therapists

I have received extensive postgraduate training in order to treat a wide range of concerns: anxiety, trauma, depression, grief and loss, family and relationship issues. My treatment approach is tailored to your unique needs and personality. Your goals are very important to me.

Approach to Counseling Our relationship is a unique one. We may be discussing things that are confusing and troubling and at times this discussion may be intensely personal. We will work together as equals, exploring therapeutic goals. I may offer suggestions or interpretations, recommend assignments to be completed outside of the session, or use techniques designed to help you reach your goals. Your responsibilities include making an honest attempt to communicate about how this process is working for you, being on time and paying for services as agreed upon. If you have ***any*** questions, I encourage you to ask me. Sometimes the process called therapy is a challenging one, but it can also permit change and a meaningful, rewarding adventure.

Informed Consent An important aspect of this relationship includes the issue of confidentiality. If I see you outside of the office (for instance, in a restaurant or store), I will not acknowledge that I know you unless you do so first. You have the right to confidentiality regarding any information obtained or discussed within the counselor-client relationship. No information will be released without a signed consent from you specifying what specific information should be released and to whom. At times, to maintain the highest possible standards of care for you, I may discuss aspects of your treatment with appropriate supervision and reserve the right to refer you to another therapist if it does not appear that you are benefiting from this relationship.

There are circumstances where I must, **by law**, break confidentiality. If I become aware that anyone, including yourself, is in clear and imminent danger to yourself, others or society, I must take action (contacting the appropriate authorities) to protect those who are in danger. Where there is a question of children being abused, Child Protective Services will be contacted. You need to be aware that a court can subpoena your records should you be involved in future legal matters. You also need to be aware that I will not make any court appearances on your behalf if requested to do so. My goal is to protect the integrity of our relationship and appearing in court would compromise the therapeutic relationship we have developed.

Fees The fee for the initial assessment session is $240.00. The fee for all following 50-minute sessions (individual, couple, or family) is $160.00. Any correspondence such as email, text, phone conversations and requested written correspondence will be charged at the $160 per hour session rate. We accept cash, checks and credit cards as form of payment. If your check does not clear your bank, you will be charged an additional fee of $25.00. Payment is due at the beginning of each session so please have your payment ready before you come into the session. If you pay in cash, you must bring exact change. We do not keep cash on hand to make change. Your receipt will be a statement mailed or e-mailed to you upon request.

Cancellations must be made at least 24 hours in advance or you will be charged for the session. For failed (no-show) appointments, there will be a full charge. We require that these charges be paid in full before the next scheduled appointment.

Phone Calls Ridglea Family Guidance's business hours are 9:00 to 5:00, Tuesday through Friday.

Treatment of Minor

I certify that under the laws of the state of Texas, I have the legal right to authorize treatment for minor child,

_____ (name of child)

I have read, understand, and have received a copy of this Professional Disclosure Statement.

Client Name _____

Client/Guardian Signature _____ Date _____

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Informed Consent for TeleMental Health Services

The following information is provided to clients who are seeking TeleMental Health therapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

TeleMental Health Defined:

TeleMental Health means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

Limitations of TeleMental Health Therapy Services

While TeleMental Health offers several advantages such as conveniences and flexibility, it is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service, (e.g., phone gets cut off of video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see various details such as facial expressions. Or, if audio quality is lacking, I might not hear differences in your tone of voice that I could easily pick up if you were in my office.

Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As the therapist, I will take every precaution to insure a technologically secure and environmentally private psychotherapy session. As the client, you are responsible for finding a private, quiet location where the sessions may be conducted. Consider using a "do not disturb" sign/note on the door. The virtual sessions must be conducted on a Wi-Fi connection for the best connection and to minimize disruption.

Video Conferencing (VC)

Video Conferencing is an option for us to conduct remote sessions over the internet where not only can we speak to one another, but we may also see each other on a screen. I utilize ZOOM. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that ZOOM is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.)

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In Case of Technology Failure/Emergency Protocol

The most reliable backup is a phone. Therefore is always recommended that you always have a phone available and that I, your therapist, have that number. If you get disconnected from a video conference session, end and restart the session. If you are unable to reconnect within five minutes, call me at 817.731.3700. If I do not hear from you within ten minutes you agree (unless you request otherwise) that I can call you on the phone number you provide on the client information form. If you are on a phone session and your phone disconnects, call me back, or contact me to schedule another session. If I do not hear from you within ten minutes you agree (unless you request otherwise) that I can call you on the phone number you provide on the client information form. If this happens as a result of my phone of phone service, and we are not able to reconnect, you will not be charged for the session.

Emergency Management for Distance Counseling

So that I am able to get you help in case of an emergency and for your safety, the following are important and necessary. In addition, by signing the agreement form you are acknowledging that you understand and agree to the following:

- You will inform me of your location during our sessions, and will inform me if this location changes.
- You will identify on your client information form, a person whom I, your therapist, am allowed to contact in the case that I believe you are at risk.
- Depending on my assessment of risk, you, the client, or I, your therapist, may be required to verify that your emergency contact person is able and willing to go to your location in the event of an emergency, and if I deem necessary, call 911 and/or transport you to a hospital. In addition, I may assess, and therefore require, that you create a safe environment at your location during the entire time that you are in treatment with me. This may mean disposing of all firearms and excess medication from your location.

Risks / Client's Responsibilities / Client's Protection

When using technology for communication there is a risk that is may be forwarded, intercepted, circulated, stored, or even changed, and the security of the devices used may be compromised. Although I make reasonable efforts to protect the privacy and security of all electronic communication with you, it is not possible to completely secure the information.

If you use any other methods of electronic communications with me, other than the means recommended by me, there is a reasonable chance that a third party may be able to intercept that communication.

With the use of technology it is important to be aware that family, friends, co-workers, employers, and hackers may have access to any technology, devices, or applications that you use.

I encourage you to only communicate through a computer, or any other device that you know is safe. You are responsible for reviewing the privacy settings and agreements forms of any applications or technology you use. Please contact me with any questions you may have on privacy measures.

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Text Messaging

Text Messaging is not a secure means of communication and may compromise your confidentiality. Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it. Therefore, I do not utilize texting in my therapy practice, and I will not respond to a text message for your protection. If you happen to send me a text message by accident, you need to know that I am required to keep a copy or summary of all texts as part of your clinical record that addresses anything related to therapy.

Email

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that addresses anything related to therapy. If you are in crisis, please do not communicate this to me via email because I may not see it in a timely manner.

Structure and Cost of Sessions

I offer face-to-face psychotherapy when appropriate and available, however, based on your ability to make in-person sessions and my availability, I may provide virtual psychotherapy if your treatment needs determine that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you.

The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions described my general client form. Texting and emails (other than just setting up appointments) are billed at my hourly rate for the time I spend reading and responding. I do require a credit card ahead of time for TeleMental Health therapy for ease of billing. Please sign the Credit Card payment form and indicate that I may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental Health interaction.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

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Consent to Treatment

I, voluntarily, agree to receive TeleMental Healthcare assessment, care, treatment, or services and authorize Cheryl Dielman to provide such are, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such are, treatment, or services that I receive through Cheryl Dielman at any time.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Name of Client or Legal Representative Relationship to Client

_____ _____

Signature of Client or Legal Representative Date

Therapist:

_____ _____

Cheryl Dielman, LCSW-S, LPC-S, CEDS-S Date

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Authorization for Release of Information

I, _____ give permission to
(Client Full Name)

Cheryl D. Dielman, LCSW-S, LPC-S, CEDS
To:
❑Release Information To
❑Receive Information From
❑Discuss With

_____
(Primary Care Physician, Therapist, Hospital, Agency, School, ETC.)

_____
Street Address

_____
City State Zip

(_____)_____
Phone Number

(_____)_____
Fax Number

❑ Clinical Notes
❑Discharge Summary
❑Medical History
❑Psychiatric Assessment
❑Other_____
❑Treatment Summary
❑Psychological Testing
❑Social History
❑School Records

I expressly understand and agree that no legal responsibility of liability of any nature shall attach to Ridglea Family Guidance or its agents in acting upon this authorization and request. This consent is subject to revocation by the patients at any time. This release will be in effect for the length of time in treatment. A photocopy of this consent should be honored the same as the original.

_____ _____
Clients PRINTED Name Signature

_____
Date

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CREDIT CARD AUTHORIZATION FORM

Today's Date: _____ Clinician: _____

Patient's Name: _____

Card Holder Name: _____

Billing Address: _____

Street City State Zip Credit Card #: _____

Expiration Date: _____ ❑Visa ❑MasterCard ❑Discover ❑American

Express Amount: _____

I authorize Ridglea Family Guidance to keep my signature on file and to charge my credit card as indicated below:

❑This Visit Only ❑This Month Only ❑All Visits This Year

❑Monthly Arranged Payments ❑Account Balance Payoff

❑Until Canceled In Writing/Card Expiration

Cardholder Signature: _____

**********Office Use**********

Processed By: _____ Date Logged: _____

Comments: _____

_____