Mary Alvarez, Ph.D.

Licensed Psychologist

1506 Winding Way #210   Friendswood, TX 77546

281 482-0801 * 281 996-1355 (fax)

DrMaryAlvarez.com

Client Rights, Responsibilities, and Consent for Treatment

Successfully helping individuals or families deal with problems, issues, or concerns requires a healthy connection between the individual(s) and the professional. Both parties must feel comfortable with and respect each other. To assist in developing a healthy therapeutic alliance, certain client rights and responsibilities must be explained, understood, and agreed upon.

Client Rights

1. You have the right to be treated in a respectful and professional manner.
2. You have the right to confidentiality. Information contained in your chart will not be released without your written consent. In the state of Texas, confidential information may be disclosed to others without your consent in the following circumstances:
    a. If the client is under age eighteen, a parent(s) or legal guardian(s) may have access to the child/adolescent's records and may authorize their release to other parties.
    b. If you are determined to be in immediate danger of hurting yourself.
    c. If you are determined to be in imminent danger of hurting someone else.
    d. If you disclose the abuse or neglect of a child/adolescent, an elderly person, or a disabled person.
    e. To comply with all court-ordered release of records, which does not require your consent.
    f. If you disclose the sexual misconduct of another mental health professional.
    g. To qualified personnel for specific program audits or evaluations.
    h. To specific individuals, government agencies, insurance companies, or businesses involved in paying and/or collecting fees for services.
    i. In legal or regulatory actions against a professional.
    j. In proceedings in which a claim is being made about one's physical, emotional, or cognitive condition.
    k. When otherwise legally required.
3. You have the right to know the assessment of the current problem(s), the recommended treatment, and Dr. Alvarez' treatment orientation.
4. You have the right to know Dr. Alvarez' fees in advance of treatment.
5. You have the right to refuse psychological treatment. You may be advised against such a decision and any negative consequences that may result from your refusal to be treated will be discussed with you.
6. You have the right to be referred to another qualified behavioral health provider if you refuse psychological treatment by Dr. Alvarez or you may request a referral for any other reason.

Client Responsibilities

1. You are responsible for providing Dr. Alvarez with accurate information regarding yourself, your family, children, past history, and concerns/problems, as well as notifying Dr. Alvarez of any changes or unexpected events that may have occurred during the course of treatment.
2. You are responsible for asking Dr. Alvarez questions if you don't understand something, as well as discussing any concerns that you have regarding the recommended treatment.
3. You are responsible for being an active participant in the treatment and following the agreed-upon treatment recommendations and direction.
4. You are responsible for keeping your appointments, arriving on time, and notifying Dr. Alvarez at least 24 hours in advance if you are unable to keep an appointment.
5. You are responsible for understanding your insurance coverage, benefits, plan, provisions, and exclusions ***if*** insurance will be utilized. There are some services provided by Dr. Alvarez in which she does not accept insurance benefits and those will be discussed in advance of any treatment or evaluation.
6. You are responsible for paying for the psychological services of Dr. Alvarez, including the deductible and co-payments, *regardless of insurance coverage*.
7. You agree to resolve any and all disputes arising from the professional relationship via mediation first and arbitration second, if necessary. The mediator shall be a neutral party agreed upon by you and Dr. Alvarez and all associated costs shall be divided equally. Any arbitration will be considered binding and settled.

Consent to Treatment

1. I understand that in the case of a ***life threatening emergency situation***, I am to call 911 or travel to the nearest emergency room.
2. I understand that a psychological evaluation and/or treatment by Dr. Alvarez is not a guarantee that my problems or concerns will be completely eliminated and I understand that the practice of psychology is not an exact science.
3. I understand than an appointment not canceled at least 24 hours in advance will result in a full office fee charge ($175) to me.
4. I understand that Dr. Alvarez is a licensed psychologist in the state of Texas and that she is a sole practitioner. In the event that she cannot fulfill her duties as a psychologist, her records will be transferred to a psychologist of her choice.
5. I have read, understood, and agreed to the Client Rights and Responsibilities.
6. I consent to psychological evaluation and/or treatment from Dr. Alvarez.

____ ________________

Signature of Client or Guardian Date

____

Printed Name of Client of Guardian