TIFFANY STANLEY
Sex & Relationship Therapy

Psychotherapist-Client Services Agreement

Welcome to my practice. This document contains essential information about my professional services and business policies.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client, and the particular concerns that you are experiencing. There are many different methods that I may use to deal with the concerns that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be the most successful, you will have to work on the things that we talk about, both during our sessions and at home

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. However, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific concerns, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Your first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work with include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own options, and determine if you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you to set up a meeting with another mental health professional for a second opinion.

Contact

Email: drtiffanystanley@gmail.com

Phone: 512-585-4098

Please understand that due to my work schedule I am often not immediately available by telephone or email. I will not answer a phone call, text or email when I am with a client. I will make every effort to return your call, text or email on the same day, except for weekends or holidays.

Emergencies

If you have an emergency, please call 911 or go to the nearest emergency room. If it is not an emergency, but you require counseling services while I am not available, you may call Texas Crisis Counseling Help Line at 512-472-4357.

Session Rates

Sessions may be in the form of: In-office, Telephone and Online therapy

Initial Session:

Individual Session: duration 60 minutes, $285 each session

Couple Session: duration 60 minutes, $335 each session

On-going Sessions:

Individual Session: duration 50 minutes, $235 each session

Couple Session: duration 50 minutes, $285 each session

*Therapy Scholarships are available based on qualifying needs

Late Attendance, Late Cancellation & No Show

Missed or late canceled sessions (less than 48 hours prior to your appointment) will be charged the full session rate to the credit card on file. Notice of personal or family emergencies (such as medical or accident) will be accepted, but must be provided, to have the cancelation fee waived.

If a client is more than 15 minutes late to a scheduled session, without notice, the session will be considered a late canceled session. The client will be charged the late cancel fee to the credit card on file. Clients may call or text Tiffany Stanley, to provide notification of delay in their arrival.

Other Fees

For all research, copying and administrative work, requested on your behalf, including any requests for paperwork and/or clinical evaluations, not including releases and insurance paper work required for your care, you will be charged $400 per hour. On rare occasions, therapists may have to appear in court on your behalf, but only if subpoenaed or court-ordered by a judge. In these cases, therapist testimony and/or case consultation will be provided at the cost of $400 per hour, to be paid by the subpoenaing party at the time of court related service. These services include, but not limited to, travel, meetings with attorneys and court appearances.

Client requested consultation with others (such as consultation with medical support), will be charged at fee rate of: free for first 15 minutes, then $50 per 15 minute increments. A signed authorization of release is required for all requested consultation.

Insurance

Tiffany Stanley, PhD., MA, NCC, LPC-S is considered an out-of-network provider for all insurance panels. The client is solely responsible for the full session fees and responsible for confirming their benefits and managing claims with their insurance company. With advance request, the counseling offices will gladly provide the client a statement of payments, called a Superbill, that can be submitted to the insurance company for possible reimbursement.

Financial Agreement

Should a balance appear on the client's account with Tiffany Stanley, PhD., MA, NCC, LPC-S, the client/responsible party authorizes the use of the following credit card to pay for any unpaid balance on any other accounts. I give the Counseling offices of Tiffany Stanley, PhD., MA, NCC, LPC-S permission to charge my credit card for session fees or other agreed upon fees/payments. I personally guarantee the accuracy of the information provided and understand the provisions of the financial policy and Authorization to Transfer funds clause. I have read, understand and agree with the provisions of the financial policy.

_____ _____

Card Holder and Client Signature Date

By signing below, I acknowledge that I have been provided the Psychotherapist-Client Services Agreement, that I understand and agree with the information provided and that all of questions regarding this agreement have been answered.

_____ _____

Client Signature Date

- -

*This portion of document will be destroyed once the information is entered into the encrypted system. After which the office will only have access to the last four numbers of your credit card.

Financial Payment Agreement: All clients are required to maintain an active credit card on file. Should a balance appear on the client's account with Tiffany Stanley, PhD., MA, NCC, LPC-S during care for the client, the client/responsible party authorizes the use of the following credit card to pay for any unpaid balance on any accounts. The credit card information is held within a secure, encrypted data system.

Please complete if you do not currently have an active credit card on file:

Type: Visa, MC, Amex, Other

Cardholder Name: _____

Credit Card Number: _____

Expiration Date: _____

Billing Zip Code: _____

Security Code: _____ (3/4-digit number on the card)

CONTACT INFORMATION: THIS SHEET MUST BE FILLED IN COMPLETELY

Client's First Name: _____

Last Name: _____

Preferred Name: _____

Address: _____

City: _____ State: _____
Zip: _____

Best contact phone number (work/home/mobile) _____

May I leave a message? Yes or No

Alternate phone number (work/home/mobile)_____

May I leave a message? Yes or No

Email Address: _____

(Email is not considered a confidential means of communication.) Is email correspondence accepted? Yes or No

Birthdate ___ /___ /___ Age _____

Gender ____F M____M-F____F-M ___ Other

Name of Spouse/Guardian _____

Phone _____

Person Responsible for Payment _____

Signature of Person Responsible for payment _____
(Must be signed for services to begin)

Emergency Information: In case of emergency, contact:
Name_____ Relationship_____
Phone_____

Physician/Psychiatrist _____
Phone _____

Please tell me how you learned about my practice:

Physician Counselor Friend Internet Magazine Other

Name of Referral: _____

PERSONAL INFORMATION

Client Name: _____

Preferred Name: _____

Date: _____

If you need any more space for any of the questions, please use the back of the sheet.

Marital Status (more than one answer may apply):

Single_____ Married_____ Partnered_____ Dating_____ Engaged_____ Widowed_____
Separated _____Divorce in process ____ Unmarried, living together ____

Length of time in current relationship: _____

Total number of marriages: _____

Assessment of current relationship (if applicable):

_____ Great _____ Good _____ Fair _____ Poor

How would you describe yourself in social relationships (at school, work, with friends):

___Affectionate ___ Aggressive

___ Avoidant ___ Follower

___ Leader ___Friendly

___ Outgoing ___ Shy/withdrawn

Other (specify): _____

What is your sexual orientation?

Heterosexual_____ Gay Male_____ Lesbian_____ Bisexual_____ Transgender_____
Questioning_____ I'd rather not say_____

How do you identify your gender?

Male Female Male-Female Female-Male

Comments: _____

Are you currently experiencing sexual concerns? (sexual desire concerns, difficulty with arousal or orgasm, sexual pain, gender or sexual orientation concerns, etc.)

_____Yes _____ No

If yes, please describe:

_____

Is your partner currently experiencing sexual dysfunctions?

_____Yes _____ No

If yes, please describe: _____

What is your ethnicity?

Ethnicity: White_____ Black/African American_____ Latina/Latino_____

American _____ Indian_____ Asian American_____ Multi-racial_____ European_____ Other_____

Are you currently involved in any active legal cases (traffic, civil, criminal)?

_____Yes _____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges:

_____

Are you currently enrolled in school? Yes ____ No

What is your highest level of education? ___ High school /GED

___ Vocational ___ College ___ Post Graduate Other: _____

Are you currently employed? ____Yes ____ No

How long have you been employed at your current location? _____
Where are you employed? _____

Describe your areas of special interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health,

hunting, fishing, bowling, traveling, etc.)

_____

What do you do for yourself as self-care activities?

_____

List any recent health or physical changes within the last year:

_____

Family history of medical or psychological problems:

_____

Do you use any of the following chemical? (if yes, quantity)

Alcohol

Illegal Drugs

Caffeine

Nicotine

Over the counter

Prescription drugs (name, dosage and usage):

_____

_____

Counseling/Prior Treatment History

When:

Where:

For how long:

With whom:

Have you participated in a drug/alcohol treatment program? _____ Yes ____ No

If yes, please explain: _____

Have you ever been hospitalized for mental concerns? _____ Yes ____ No

If yes, please explain: _____

Have you been involvement with self-help programs? _____ Yes ____ No

If yes, please explain: (Examples: AA, Al-Anon, NA, Overeaters Anonymous)

_____

Have you had suicidal thoughts and/or attempts: ____ Yes ____ No

If yes, explain: _____

Do you feel suicidal at this time? ____ Yes ____ No

If yes, explain: _____

Do you experience any of the following concerns? If so, please check the behaviors and symptoms that occur to you more often than you would like and indicate the degree (1 to 5) to which you have concerns about the following:

No concerns (1) and Severe concerns (5)

*Any with a 3, 4 or 5 scoring, please explain.

Depression 1 2 3 4 5 _____

Anxiety 1 2 3 4 5 _____

Phobias/fears 1 2 3 4 5 _____

Concerns regarding sexual functioning, sexual orientation or identified gender

1 2 3 4 5 _____

Sexual compulsion/addiction 1 2 3 4 5 _____

Suicidal thoughts 1 2 3 4 5 _____

Relationship concerns 1 2 3 4 5 _____

Avoiding people 1 2 3 4 5 _____

Managing Stress 1 2 3 4 5 _____

Irritability1 2 3 4 5 _____

Anger management 1 2 3 4 5 _____

Self-esteem 1 2 3 4 5 _____

Eating Concerns/body image 1 2 3 4 5 _____

Feelings of Grief, shame or regrets 1 2 3 4 5 _____

Hopelessness 1 2 3 4 5 _____

Loneliness 1 2 3 4 5 _____

Mood Swings 1 2 3 4 5 _____

Difficulty with Assertiveness 1 2 3 4 5_____

Communication difficulties 1 2 3 4 5 _____

Expressing feelings 1 2 3 4 5 _____

Decision making 1 2 3 4 5 _____

Religion/Spirituality 1 2 3 4 5 _____

Self-injurious behavior 1 2 3 4 5 _____

Alcohol/drug use 1 2 3 4 5 _____

Computer overuse 1 2 3 4 5 _____

Domestic violence 1 2 3 4 5 _____

Sexual assault/abuse 1 2 3 4 5_____

Childhood abuse 1 2 3 4 5 _____

Other trauma 1 2 3 4 5 _____

Finances 1 2 3 4 5 _____

Obsessive thoughts 1 2 3 4 5 _____

Worrying 1 2 3 4 5 _____

Physical health concerns 1 2 3 4 5_____

Sexually Transmitted Disease 1 2 3 4 5_____

Sleeping problems 1 2 3 4 5 _____

Fatigue 1 2 3 4 5 _____

Impulsivity 1 2 3 4 5 _____

Distractibility 1 2 3 4 5 _____

Memory impairment 1 2 3 4 5 _____

Hallucinations 1 2 3 4 5 _____

Other _____

Any additional information that would assist your therapist, in understanding your concerns or problems:

_____

_____

_____

_____

_____

_____

_____

What are your goals for therapy?

1)

2)

3)

Thank you for completing these documents.

I look forward to working with you.

Tiffany Stanley