



Ensemble Therapy

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STATEMENT OF POLICIES

Thank you for choosing me as your child's counselor. I realize that starting counseling is a major decision and you may have many questions. This sheet may answer any questions that most clients have regarding psychotherapy and my services. Please read it carefully and ask for any clarification before signing the Informed Consent statement at the bottom of the form. If you have other questions or concerns, please ask, and I will try my best to give you all the information you need.

The modalities of outpatient psychotherapy utilized in my office are widely accepted forms of psychological treatment. As with all forms of clinical treatment however, there are risks to be considered in the process of making an informed decision. This form is designed to inform you of these risks as well as the potential benefits of outpatient therapy, and to discuss the general policies and procedures of my office.

QUALIFICATIONS AND CREDENTIALS

I have a Masters Degree in Professional Counseling from Texas State University, a program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), and a Bachelors Degree in Psychology from The University of Texas in Austin. I am a Licensed Professional Counselor (LPC), Registered Play Therapist (RPT), Nationally Certified Counselor (NCC) and Professional School Counselor. I am a member of the Texas Counseling Association (TCA), Association for Play Therapy (APT) and American School Counselor Association (ASCA).

OVERVIEW OF CLINICAL SERVICES

Prior to beginning treatment, it is important for you to understand my approach to child therapy. I offer counseling for children ages 3-17 years in both individual, group and family sessions using play therapy and other developmentally appropriate techniques. Play is the language of children and play therapy is a treatment approach that encourages children to play out their fears, worries and conflicts. It is my policy to provide you with general information about treatment status. I will also meet with you on a regular basis to consult about changes as well as to find out how your child is managing both at home and at school. If I feel it is necessary to refer your child to another mental health professional with more specialized skills, I will share the information with you. While therapy should end through mutual agreement once desired goals have been reached, you have the right to end therapy at any time. I will honor that decision; however, I ask

that you allow me the option of having three (3) closing sessions with your child to appropriately end the therapeutic relationship. Children may have already experienced several abrupt endings in their young lives, let us not repeat the experience for them.

DURATION OF THERAPY:

Goals for therapy may be specific (change in behavior, improved relations with friends or family), or more general (less anxiety, better self-esteem). The length of therapy depends on the complexity and severity of problems. The full spectrum is possible: it ranges from "brief" interventions (3-8) sessions to long-term therapy (6 months - 3 years). I encourage parent participation in all phases of child treatment. As the parent, it is important for you to support your child's work with me by making sure that appointments are kept and offering encouragement as needed.

TYPES OF THERAPY:

During treatment, I often use a variety of outpatient treatment modalities, which include Individual, Group and Family Psychotherapy. Clinical services include:

- Play Therapy: the use of play and other non-verbal techniques as a means of enhancing a child's confidence, trust and ability to communicate
- Art Therapy: the use of art media (paint, clay, collage, etc.) to assist in expressing & resolving their conflicts. Also helps promote self expression and build confidence
- Sand Tray Therapy: the use of a sand tray and miniature figurines to express relationships, resolve conflicts and traumas by externalizing and developing a sense of mastery
- Bibliotherapy: the use of children's literature to normalize a child's experiences, reduce a sense of isolation and teach alternative strategies to solving problems
- Client/Person-Centered Therapy: a nondirective form of talk therapy, guiding clients in subtle ways to achieve their full potential
- Solution-Focused Therapy: a form of talk therapy that is future-focused, goal-directed, and emphasizes solutions, rather than on the problems that bring clients to seek therapy
- Child Parent Relationship Therapy (CPRT): 10 sessions that train parents to be therapeutic agents with their own children in a supervisory and supportive atmosphere; includes didactic instruction, demonstration play sessions & required at-home play sessions
- Family Play Therapy: working as a supporting unit to learn about each other, communicate, resolve conflict, and build relationships

My treatment approach is based upon each client's specific clinical needs as identified during the initial session(s). The client's therapy options are then discussed and a plan for treatment is determined. A client's needs sometimes change over the course of their outpatient therapy, which may necessitate a reevaluation of their treatment plan. When this occurs, treatment options are once again discussed and determined by the client and therapist. If, at any time, the client and/or therapist believe the client's clinical issues require alternative or additional resources, every effort will be made to assist the client in locating these resources.

APPOINTMENTS:

Office hours are Monday through Thursday, 10:00am to 8:00pm. Services are by appointment only and are made by calling 512-762-4030 or emailing jaclyn@ensembletherapy.com. If I am with a client it will go to my voicemail and I make a reasonable effort to return any call made during normal business hours within 24 hours, weekends and holidays excepted. Calls received late in the day may not be returned until the following day. Messages left after hours or on weekends or holidays will normally be returned the next business day.

BENEFITS AND RISKS OF TREATMENT:

Therapy can be beneficial to your child in a variety of ways. Your child will receive emotional support, will learn to understand feelings and problems and will be encouraged to try out new solutions to old problems. While therapy may provide significant benefits, it may also pose risks. Therapy may elicit uncomfortable thoughts, feeling or memories. The risks or potential side effects of participating in psychotherapy may include increased levels of stress and anxiety, relationship disruption, and emotional reactivity as sensitive areas are explored. Another risk is that psychotherapy may not resolve your problem or concern. I will assess progress on a session-by-session basis. Ongoing lack of progress may be reason for referral.

FEE STRUCTURE AND CANCELLATION POLICY:

Sessions are expected to begin promptly and end at the scheduled time. Although it is understood that there may be instances when you arrive late for a session, late arrival will not extend the scheduled ending time for the session. Cancellation of an appointment requires **24 hour advanced notice**. Otherwise, the client will be charged the **full fee** for the missed session. If claiming insurance for session payment and cancellation does not occur at least 24 hours in advance, you will be charged the full session fee for the missed session. Emergency circumstances (i.e., hospitalization, accident, a death in the family) will be addressed on an individual basis. If your child is contagious, has fever, is vomiting, has incessant coughing, has a profusely running nose, please call me as soon as you notice these indications as I do not wish to put other clients at risk of illness. If you need to reach me prior to scheduled therapy sessions, you can leave me a message at 512-762-4030. I will return your call as promptly as possible. I am also expected to be on time, and will offer appropriate remedy if late, such as making the time up or pro-rating the fee. I understand that non-adherence to these policies may result in termination or suspension of services.

FEE/PAYMENT

Initial Consultation (50 min/75 min)	\$175/\$200
Individual Session (50 min)	\$125
Parent Consultation (50 min)	\$150
Family Session (90 min)	\$225

Child Parent Relationship Class (10 sessions) \$550

School Consultation/Visit	\$325/hr
Home Consultation/Visit	\$325/hr
Legal Consultation/Court	\$475/hr

Payment is due at time of service and is accepted in the form of cash, check (made out to Jaclyn Sepp) or credit card. There is a **\$25 fee for any returned checks**. That \$25 fee is due at the time of your next session, along with the payment for that session. If I receive two (2) returned checks from you, I will require that you pay using cash or credit card only from that point on. I also accept payment at the beginning of the month in advance of sessions scheduled for that month. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information (your name, nature of service provided, and amount due). I will inform you in writing if I intend to exercise that option, to provide you with a final opportunity to make payment arrangements.

AFTER HOURS POLICY/PROCEDURES:

If you need to contact me, you can leave me a confidential voicemail and I will make every effort to return your call promptly, with the exception of weekends and holidays. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact as necessary. If at any time, you are unable to get a response and your need is life threatening, please contact your physician or go to the nearest emergency room or call 911. I do not provide 24 hour crisis or emergency services.

CONFIDENTIALITY

Therapy is most effective when a trusting relationship exists between the counselor and the client. Privacy is important in securing and maintaining that trust. Specific details of the information children share with me in sessions is not shared with parent (unless the child gives me his/her consent) so as to encourage children to be honest and forthcoming and to maintain an emotionally safe environment for them. I will speak with you in a general way unless there is a danger to the child's life. I will provide you with summaries of treatment goals, plans, progress and recommendations. As part of the therapeutic process I encourage children to share information with their parents. Sometimes I ask the child and parent to meet with me together so that the parent can voice concerns or ask questions. However, there are specific exceptions to this confidentiality which include the following:

LIMITATIONS TO CONFIDENTIALITY:

1. When there is risk of imminent danger to your child or another person, Texas State Law **requires** any therapist to notify the legal authorities. This includes providing information that indicates there is reason to believe that a client is being abused, a client poses a risk to others, or a client poses a risk to themselves. Additionally, if there is suspicion that your child is being sexually or physically abused or is at risk of abuse, I am mandated to take steps to protect your child and to inform the proper authorities.
2. If a client reveals to the therapist any evidence of professional misconduct (e.g., sexual involvement) perpetrated by a previous clinical provider, the current therapist is required to report this information to the state licensing board.

3. If your records are court ordered to be released by a judge, I am required by law to release the records to that judge for review.

Failure of the treating therapist to report in circumstances 1 or 2 mentioned above is a breach of legal and ethical standards, which can lead to prosecution, and/or loss of licensure.

Please understand that all records, written information, or any electronic data are marked CONFIDENTIAL and are kept under lock and key. No one inside or outside the office will have access to your case except for me. This applies as well to the other therapists in the office.

Information shared with a therapist is held in confidence. A signed and dated Release of Information (which clearly defines the nature of information to be shared, to whom and for how long) is required as consent to disclose confidential information. If the client is a minor, the release must be completed, signed, and dated by a parent or legal guardian.

DIVORCE AND CUSTODY CASES

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you must agree before we enter a counseling relationship.

1. If I am seeing a child whose parents are in the process of divorce or who are already divorced, I require a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and I will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.
2. I will provide an identical summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and I will offer and encourage opportunities for both parents to participate in parent consultations along the way.
3. I will provide treatment that will help facilitate your child's adjustment to the separation or divorce but I do not provide forensic interviews, custody or visitation evaluations, or release of records. I do not serve as an expert witness or provide testimonial services in custody battles. By signing this form you agree not to subpoena me to court for testimony or for disclosure of treatment records.

I understand these policies.

Printed Name

Client Signature

Date

PROFESSIONAL RELATIONSHIP AND ROLES

While our sessions may be intimate psychologically, it is important for you to understand that we have a strictly professional relationship at all times. Our contact, other than chance meetings, will be limited to appointments you arrange with me. I will not be able to attend any social gatherings, accept gifts over \$50, or relate in any other way than in the professional context of our counseling sessions. If we meet by chance in public, I will not approach you so that confidentiality is upheld. If you choose to approach me, that will be your choice.

EMAIL AND TEXT MESSAGING:

Because I do all of my own scheduling, I often use email or text messaging to make appointments with clients or their parents/guardians. Additionally, email and text messaging may be used to confirm appointments or inform me of cancellations or rescheduling. Because these modes of communication potentially expose your protected health information, you must provide me with consent to communicate in this manner and agree to hold me harmless should an unintended breach occur. Email and text messaging are not completely secure or confidential. Any electronic transmissions of information by you are retained in the logs of your internet service provider. While it is unlikely that someone will be looking at those logs, they are, in theory, available to be read by the system administrator of the internet service provider. Emails I receive from you and my responses will become part of your treatment records.

Client Signature

Date

SOCIAL MEDIA:

I do not accept friend or contact requests from clients on any social media site (Facebook, Instagram, LinkedIn, etc). Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client and can blur the boundaries of the professional relationship. I do maintain a Website, Blog, a Facebook Business Page, an Instagram Business Page and a professional presence on Twitter, Pinterest and LinkedIn to allow people to stay informed of events and topics of concern in the mental health field. I have no expectation that you as a client will want to follow me on any social networking sites. These pages are viewed by the public and anything you should comment on or like will have your name listed and could compromise your confidentiality. Clients are not to use messaging features on social media sites to contact me. These sites are not secure and could compromise confidentiality.

VIDEO OR AUDIO RECORDINGS:

You acknowledge and by signing this form, agree that neither you or I will record any part of the sessions unless you and I mutually agree in writing that the session will be recorded.

ADDITIONAL INFORMATION:

You acknowledge and by signing this form agree to allow me to photograph art work and scenes created by your child and to use these photographs in a professional article, book, post or at a professional training. There will be no identifying information except for the age and gender of your child.

PLEASE NOTE:

Jaclyn N. Sepp, MA, LPC, RPT, NCC is an independent, licensed counselor and is solely responsible for her clinical practice, Ensemble Therapy. Other clinicians practicing in the office are separately licensed, independent practitioners and are professionally and legally responsible for each of their respective practices. Thus, unless otherwise stated in writing, Jaclyn N. Sepp, MA, LPC, RPT, NCC and those practitioners are affiliated through sharing office space only.

If you have any complaints about my services rendered, please openly discuss them with me. This process can enhance our therapeutic relationship and can increase your progress. If you have a concern or problem regarding therapy that you and your therapist are unable to work out, you may wish to contact the Texas State Board of Licensed Professional Counselors at 512.834.6658 or 1.800.942.5540.

CONSENT FOR MINOR

I, _____, hereby provide my consent for _____ to participate in an initial evaluation and psychotherapy with Jaclyn N. Sepp, MA, LPC, RPT, NCC. I have read this form in its entirety and understand and agree to the information contained in it. I understand I can revoke this consent at any time, which must be done in writing.

Printed name of child client

Printed name of child client's legal guardian

Parent/Guardian Signature

Date

Jaclyn N. Sepp, MA, LPC, RPT, NCC

Date

INFORMED CONSENT

I, _____, (please print name) have read and fully understand the information provided in the Statement of Policies document regarding the various services provided by this office and the potential risks and benefits of outpatient psychotherapy. I also understand the obligations and limitations of confidentiality within the context of the client/therapist relationship. I agree to make payment at the time of service. I agree to cancel appointments only in the event of extreme necessity and I understand that I will be charged full fee unless I provide 24 hours advance notice. I understand that I can leave therapy at any time and if I choose to do so will be assisted by the therapist in finding other clinical resources if any are desired.

By signing this document I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. If I decide to terminate treatment I will discuss termination before ending treatment.

Before you sign below, please ask any questions you may have of this document. **Your signature acknowledges agreement and understanding:**

Printed name of child client

Printed name of child client's legal guardian

Parent/Guardian Signature

Date

Jaclyn N. Sepp, MA, LPC, RPT, NCC

Date