Informed Consent

Welcome to my practice. I appreciate the opportunity to help you.

As you will be investing time, money, and energy into psychotherapy and/or nutrition therapy, I believe you should feel comfortable with the professional you choose. When you feel this way and know what to expect, therapy is more likely to be helpful to you.

About Me:

My name is Nimisha Patel and I am a Licensed Clinical Social Worker, Licensed Dietitian and a Certified Eating Disorder Specialist practicing in Texas. I have a Honors in Nutrition and Medical Dietetics from the University of Illinois at Chicago in 1988 and Masters in Social Work in 1997 from Rutgers University in New Jersey. I have worked in outpatient offices, Eating Disorder partial care, intensive outpatient and inpatient programs and a residential program for addiction treatment.

I use my counseling skills to help individuals and families, struggling with Depression, Anxiety, and/or Eating Disorders. These complex struggles require personalized emotional and nutrition help to reach a lifestyle where people can manage these conflicts and spend more time and energy on meaningful activities.

About Treatment

- **In our treatment plan we will list our goals and the methods we will use. We will evaluate our progress and change our treatment plan as needed.**

- **If you would like to stop therapy or take a "time out" to try it on your own, we should discuss this. We can often make such a "time out" be more helpful.**

- **I may recommend you seek a consult with another professional if there is a treatment I cannot provide. I will fully discuss my reasons with you and coordinate services with other treating professionals.**

- **As an ethical therapist, I cannot continue to treat you if my treatment is not working for you. Likewise, if you are not satisfied with any area of our work, please raise your concerns with me as soon as possible.**

About Our Relationship

State laws and the rules of the NASW require me to keep what you tell me confidential (that is, private). Please review the HIPPA Policy handout.

Financial Policies: About Our Appointments

Individual Adults and Adolescents Session Fees:

$150.00/Initial Assessment (60minutes) $125.00/Follow Up (45minutes)

Telephone or in-office extended sessions may be needed at times in our therapy. If so, there will be a charge of $25/15minutes.

Your scheduled session time is reserved for you. Please note there will be a charge for the session for cancellations with less than 24 hours notice or no shows, for other than the most serious reasons.
I understand and agree to the above financial policies and will only be charged, if I do not meet these cancellation policies. I agree for the following credit card information to be securely filed (_____Initial):
Credit Card #_____ Type_____ Exp. Date _____ CCV: ___

Financial Policies: Responsible Party

Part 1. Complete this part if you are the parent/legal guardian of a minor under 18.
Name of Parent or Legal Guardian: _____DOB: _____
Social Security Number: _____
Address: _____City: _____State: ___Zip Code:
Home Phone: _____Mobile Phone: _____
Email Address: _____

Part 2. For all individuals seeking services.
Please circle the form of payment or insurance you wish to use for services.

Self Pay: Cash / Check / Credit card
Credit Card #_____ Type: _____ Exp. Date: _____CCV:___

Part 3. For individuals using insurance only. Please call your insurance company and check your behavioral health benefits before your session.
Subscriber Name: _____ Relationship to Client_____
Phone#_____ Client DOB: _____
Address: _____
Insurance Carrier: _____Insurance Phone#_____
CoPay/Coinsurance_____ Member #_____

I,_____ authorize Nimisha Patel, LCSW, RD/LD to keep my signature on file for insurance reimbursement purposes only and I understand that insurance will reimburse her, as an in network provider, for services I have received._____(Initial)

Financial Policies:

I understand that an attempt to develop a payment plan will be made if I am unable to meet my financial commitment to my sessions. In the event I still do not meet these commitments, I understand my accounts may be subject to collections.

I understand that preparation of forms and reports for disability, schools and court time, etc will also be billed to me at $25/15 minutes.

Emergency Contact Information:

I understand Nimisha Patel does not guarantee she will be available at all times and will return voicemail or email messages daily except on weekends and holidays. If I have a behavioral or emotional crisis and cannot reach Nimisha Patel, I understand I should call my family or other social supports listed below as well as emergency services(911) or go to the nearest hospital emergency room.

Emergency Contact Name: _____ Relationship to Client: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____

Statement of Understanding

I voluntarily consent to mental health and/or nutrition therapy with Nimisha Patel, LCSW, RD/LD, CEDS the owner of Healthy Lifestyles PLLC.

I have read and understood the information and accept the terms in this Informed Consent.

_____ _____
Signature of client (or person acting for client) Date

I, Nimisha Patel, LCSW, LD, CEDS have met with this client (and/or his or her parent or guardian) and have discussed the information in this Informed Consent. I have responded to all questions and believe this person fully understands the issues discussed.

_____ _____
Signature of therapist Date

___ Copy accepted by client ___Copy kept by therapist


Healthy
Lifestyles