JOE MCCRACKEN, M.ED., LPC, LPCS
1329 N UNIVERSITY SUITE D-2
NACOGDOCHES, TEXAS 75961
936-564-7310

CONSENT FOR TREATMENT

This form is to document that I, _____, give my permission and consent to Joe McCracken, M.Ed., LPC, LPCS to provide psychotherapeutic treatment to me and or _____ who is/are my (spouse/child/children) _____.
Joe McCracken offers individual therapy, marital therapy, family therapy, relationship therapy, stress management and substance abuse therapy. Mr. McCracken utilizes a variety of therapeutic approaches, including cognitive behavioral therapy and life skills development such a communication skills, assertiveness skills, stress management skills, problem solving skills and interpersonal skills.

Mr. McCracken will work with me to establish appropriate therapeutic goals of therapy (such as symptom reduction, improved communication, etc. Goals may change as therapy progresses and my input is very important in establishing appropriate therapeutic goals. While it is sometimes difficult to anticipate how much therapy may be needed to resolve the presenting problems and achieve satisfactory progress towards the therapeutic goals, Joe will estimate the anticipated duration of treatment. The recommended frequency of treatment will also be discussed (generally weekly or every other week, but sometimes twice weekly for more severe problems). While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. I understand that because of the counseling or therapy, I/he/she/we may experience emotional strains, feel worse during treatment and make life changes which could be distressing.
I understand that in the event of an emergency, I am to call 936-564-7310 and Joe will return my call as soon as possible.

I understand that regular attendance will produce the maximum effects, but that I or we am/are free to discontinue treatment at any time. If I decide to do so, Joe requests that I notify him at least two weeks in advance so that effective planning for continued care can be implemented.

I understand that conversations with Joe will almost always be confidential. I further understand that Joe, by law, must report actual or suspected child or elder physical or sexual abuse to the appropriate authorities. In addition, Joe has a legal responsibility to protect anyone a client may threaten with violence, harmful or dangerous actions (including those to myself) and may break confidentiality of our communications if such a situation arises. I understand that Joe will make reasonable efforts to resolve these situations that Joe may sometimes consult about my treatment with other professionals, who are also legally bound to maintain my confidentiality. My name will not be used in such circumstances without my permission. Similarly, if Joe is out of town or unavailable, please call the emergency hotline number. With my written permission, my records may be released to another professional or agency. Records may also be released in judicial proceedings as specified by law. Joe will discuss with me confidentiality regarding treatment of my child or spouse.

I understand that I am financially responsible for this treatment. I understand that the rate per 45-50 minute session of psychotherapy is $100.00 hour, and that payment is due at the time of service, unless Mr. McCracken agrees to other billing arrangements. If I am covered by a managed care plan for which Joe is a participating provider, the rate I am responsible for will be determined by Joe's contract with the managed care plan. Generally Joe will file insurance claims and I am responsible for the deductible, copay amounts, and the difference between Joe's normal rate and the amount covered by the insurance plan (or in the case of managed care plans for which Joe is a participating provided and for any difference between Joe's contracted rate and the actual amount paid by the managed care insurance plan). I may also choose to contract with Joe to provide services, which may not be covered by my insurance plan. (Marital or family therapy is not covered by many insurance plans). Services provided under Workers Compensation will be reimbursed solely by Workers Compensation.

In the case of Medicaid, the allowable rates are established by the state of Texas or by the federal government..

The regular fee (or the allowable charge under managed care) will be billed directly to me for any missed appointments that I have not cancelled at least 24 hours in advance. (Mr. McCracken may make an exception in the event of an emergency). Overdue accounts may be referred to a collection agency and Joe will notify me in advance to give me an opportunity to take care of an overdue balance prior to the account being turned over to a collection agency.

Dual relationships such as social relationships or business relationships are unethical and are not a part of Joe McCracken" practice.

I know of no reason why I/he/she/we should not undertake this therapy and K/he/she/we agree to participate fully and voluntarily.

I understand that Joe McCracken is providing services as a solo practitioner under his professional limited liability partnership McCracken Counseling Center and that Joe McCracken is not in business with nor shares profits with other individuals in this office suite.

Joe McCracken holds a Master's Degree in Education and is a licensed professional counselor in the state of Texas.

Joe McCracken received both his BS in Psychology (1989) and his M. Ed. (1993) from Stephen F. Austin State University. He has additional training in community crises intervention, behavioral concerns including depression, self-esteem, stress management, anxiety reduction, relationship problems, career development and family issues.

I agree to inform Joe if I have any concerns that arise during the course of treatment regarding my therapy or the fees for my therapy and Joe will work with me to attempt to resolve these concerns.

Consumer Complaint Hotline:	1-800-942-5540
Texas Board of Professional Examiners-LPC:	512-834-6658

Signature: _____
(Client or person authorized to consent for client)

Date: _____