**Sheila A. Jenkins, Ph.D.**

# Psychologist

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**Informed Consent and Practice Information for Psychological Services**

Welcome to the private practice of Dr. Sheila Jenkins. This document contains important information about my professional services and business practices. Please read this document carefully and note any questions you might have so I can answer them.

My qualifications:

Since 1993, I have been licensed to practice as a psychologist in the state of Texas by the Texas State Board of Examiners of Psychologists. I earned a PhD in counseling psychology from the University of Georgia in Athens in 1992 and complete pre-doctoral internship training at the Houston VA Hospital from 1991 to 1992. Since then, I have had extensive training in providing psychological services to children, adolescent, adults, couples, and families, as well as in performing psychological testing.

Purpose and Nature of Services Provided:

Psychologists help patients with mental, behavioral, emotional, and cognitive difficulties. Psychological consultation and counseling are intended to help you reach a better understanding of problems or increased self-awareness and insight. It is also intended to work toward improvement of the identified problems, offer support in problem solving, provide some symptom relief, and improvement in coping with daily life activities. Your progress in counseling and the subsequent outcome depends on many factors including your level of motivation to change, the effort that you put forth in following through with agreed upon therapeutic recommendations outside of sessions, keeping your appointments, and your willingness to be open during counseling sessions.

Methods and Procedures and Risks and Benefits of Counseling:

Your first appointment at my office is called an intake. During the intake, you will complete several documents and participate in an interview to assess the nature of the presenting problem. You might be asked to complete additional checklists to gather specific information about your psychological symptoms. With your consent, family members may be asked to participate in the intake for the purpose of gathering information about your mental health.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like anxiety, sadness, fear, anger, and frustration. Also, some of the changes you make as a result of counseling may not please other people in your life. This may result in some problems in your relationships with family, friends and others. Insight gained in counseling may also disrupt a romantic relationship. Sometimes, too, it is possible for a patient’s problems to worsen immediately after beginning therapy. Most of these risks are to be expected when people are making important changes in their lives. On the other hand, counseling has also been shown to have benefits leading to feelings of happiness, reduction in unpleasant feelings, improved relationships, resolution of problems and personal and professional success. But there are no guarantees of what you will experience. The outcome is based upon our joint effort in working collaboratively toward specific goals.

Together we will typically agree on specific goals for therapy, such as symptom reduction, behavioral change, improved communication and/or interpersonal skills, the ability to return to work or school, etc. Goals will in all likelihood change as therapy progresses and should be renegotiated accordingly. I am trained in many therapeutic techniques. The therapeutic approach used in your treatment will vary and should be discussed with me whenever you have questions or when you believe therapy is not helpful.

Typically, our first few sessions will involve establishing rapport and evaluating your needs. By the end of the evaluation period, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the psychologist you select to help you on your journey. How long you stay in counseling and how often you attend sessions will depend on you. If you have questions about my treatment procedures, we should discuss them whenever they arise. If at any time you believe that I cannot help you, I will be happy to refer you to a psychologist or other mental health clinician.

Types of psychological services:

If you are a parent of a child in counseling – your participation in your child’s counseling is important for long-term gains. You may need to learn a different way of dealing with your child to facilitate and maintain gains. I will ask for your feedback and views on your (your child’s) therapy, progress and other aspects of counseling and will expect you to respond openly and honestly.

If you are a minor child – I will initially meet with all involved in parenting you. From that point forward all discussions about clinical matters and concerns about you will be done in your presence. It is important for parents to know that meetings without the patient present tend to undermine the trust and therapeutic relationship. How frequently caregivers attend counseling is something that can be negotiated at the outset of treatment and can be adjusted as needed. If one parent/guardian has custody of the child, then documentation identifying the managing conservator will be required before treatment begins.

If you are a couple in counseling - I consider the relationship between the members to be my patient. As such, couples sessions will only be conducted with both parties present. If one member of the couple is unable to attend the session it will need to be rescheduled. It should be noted that confidentiality applies to the couple and statements made in the individual assessment may be shared with the partner (or you may be asked to share the information) based on my clinical judgment. Depending on the nature of the problem, I may see individual members of the couple while conducting couples therapy.

Appointments:

I see patients by appointment only. Your first appointment or the intake varies from 45 minutes to 90 minutes. During this intake session, you will complete several forms and give information about your reason for seeking psychological services. Information will be gathered about your educational history, work history, health history, mental health history and substance abuse history. Each appointment after the intake is called a counseling session that last 45 minutes. The frequency of your visits will be agreed upon by us and may change throughout the duration of your treatment. Because I value time commitment, you will be seen at your scheduled appointment time. If for some reason, you are late to the appointment, I will see you for the remainder of your scheduled time. If you miss an appointment, a no show fee of $50 will be charged because the time was scheduled specifically for you. To avoid this fee, we ask that you cancel an appointment at least 24 hours prior to your appointment so that we might offer it to another patient.

Fees:

For the initial office appointment or intake, I charge $175. For subsequent counseling sessions, the fee is $150 for a 45 minute session. Additional fees include $25 for returned checks and $50 for no show appointments. The fee for psychological testing varies depending on the type of testing, the instruments administered, and the time that it takes to complete the testing and write the report. Prior to scheduling testing, I will inform you of the exact amount you will be charged for testing. All fees are due at the time services are rendered. Payments are due by check; cash; or credit cards via PayPal. I do not process credit cards or bank cards in the office.

Communication:

I can be reached by telephone at my office during business office on my office telephone number which is 713-266-9837. If I am not available, please leave a message and I will call you back within 1 or 2 days. After hours and on weekends, you may leave a message and I will respond in a timely manner to all messages. Another way to communicate with me is by email at drjenkins@drsheilajenkins.com. Even though I am the only person who checks my email, I cannot guarantee confidentiality of email communications as these transmissions are inherently unsecured. I do not communicate via text messaging with my patients, nor do I communicate on social media (Facebook, Instagram, Twitter, etc.) with my patients.

Life threatening emergencies:

If you are experiencing a crisis, please go to the nearest emergency room or call 911.

Limits on Confidentiality:

Texas law and the federal HIPAA privacy rules are designed to protect the privacy of all communications between you and a mental health professional and records of your treatment. In most situations, I can only release information about your treatment to others if you sign a written authorization. The authorization will remain in effect for a length of time you determine. You may revoke the authorization at any time, unless I have taken action in reliance on it.

Exceptions and limitations of your confidentiality include the following:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative’s) written authorization. However, if your records are subpoenaed or if a judge issues a court order for you records, I am legally obligated to comply. In the case of a subpoena, I will contact you so you and your attorney can take steps to contest the subpoena, but if you do nothing, I will obey the subpoena.
2. If I believe that you are a danger to yourself or to others, I will contact medical or law enforcement personnel.
3. If you are a minor, elderly, or disabled and I suspect you are a victim of abuse, or if you divulge information about such abuse, I am required by law to notify authorities.
4. If you file suit against me for any reason related to your therapy.
5. If a court order or other legal proceeding or statute requires disclosure of your information.
6. If you waive the rights to privilege or give written consent to disclose information.
7. If third party payers (i.e., insurance companies) or those involved in collecting fees for services require additional information.
8. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy.
9. If I learn of previous sexual exploitation by a mental health provider I am required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider. The patient has the right to remain anonymous when the report is filed.

Records and your right to review them:

Documentation of sessions consists of a summary of each meeting and may include general issues addressed, possible symptom presentation or change, level of functioning, mental status, diagnosis and treatment goals, progress and plans. Texas law requires that I maintain appropriate treatment records for at least 10 years from the last date of service. If the patient is a minor child at the time services are provided, the records are kept for 10 years after the patient’s 18th birthday.

As a patient, you have the right to review your records or receive a summary of your records. Texas law requires that all requests to review or obtain copies of your records must be made in writing. The records can be misinterpreted and/or can be upsetting to lay readers. If you request a copy of your records, I will provide them to you within 15 days of receiving the request unless I believe that to do so would endanger your life or the life of another person. I have determined that a reasonable, cost-based charge for providing you with a copy of your records will be $25.00. By law, I am not required to provide copies of requested records until the fee is paid.

Under Texas State law, a child’s parents/legal guardians have the right to examine and have a copy of the child’s records (unless the child is emancipated). It is extremely rare, however, that a parent/guardian would ever request access to these records. In general, you may review your records in my files at any time. There are some limitations regarding raw testing data, but for the most part, you have access to your information. You may add to this information or correct this information, and you may have copies of the records. I reserve the right to refuse to alter the records in any way. I have determined that a reasonable, cost-based charge for providing you with a copy of your child’s records will be $25.00. By law, I am not required to provide copies of requested records until the fee is paid.

Complaints:

You have a right to have your complaints heard and resolved in a timely manner. Please know that I take all concerns seriously, as they will be handled with great care and respect. If we cannot work things out to your satisfaction you may inform your insurance carrier and file a complaint with them or with your counselor’s licensing board: The Texas State Board of Examiners of Psychologists (800-821-3205).

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**Informed Consent and Practice Information for Psychological Services**

**Signature Page**

I have read the above agreement carefully, I understand the terms of this agreement and I agree to comply with them. I agree that this agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated AFTER the date of this agreement and must be provided to Dr. Sheila Jenkins. A copy of this agreement has the same force and effect as the original. I have also received and read the HIPAA Notice of Privacy Practices.

Informed Consent for Psychological Services:

I, Enter Patient Name (print name), have read and I understand the information presented in the document entitled “Informed Consent and Practice Information” and consent to receive treatment and/or diagnostic services from Dr. Sheila Jenkins. Furthermore, I agree to abide by the rules and policies described in the Informed Consent and Practice Information for Psychological Services document.

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Patient Signature Date

Enter Patient Name

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Patient Printed Name

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**MINOR**

**Signature Page**

I have read the above agreement carefully; I understand the terms of this agreement and I agree to comply with them. I agree that this agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated AFTER the date of this agreement and must be provided to Dr. Sheila Jenkins. A copy of this agreement has the same force and effect as the original. I have also received and read the HIPAA Notice of Privacy Practices.

Informed Consent for Psychological Services:

I, Enter Parent Name, have read and I understand the information presented in the document entitled “Informed Consent and Practice Information” and consent to receive treatment and/or diagnostic services from Dr. Sheila Jenkins. Furthermore, I agree to abide by the rules and policies described in the Informed Consent and Practice Information for Psychological Services document.

I, Enter Parent Name, the undersigned, parent and/or guardian of a minor child, Enter Child Name, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me as parent and/or guardian of said child. I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability. I realize that at times the nature and/or content of such services must remain private. Therefore, I hereby release any right I may have to the information contained in the file of my son, daughter, or ward which may be generated as a result of such services.

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Parent Signature Date

Enter Parent Name

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Parent Printed Name