Evolve Your Intimacy With Dr. Stephanie

Licensed Professional Counselor, Certified Sex Therapist & Clinical Sexologist

100 West Central Texas Expressway
Suite 208, Harker Heights, TX 76548
Ph: 254-432-5512 **Fax:** 432-272-6227
Web: evolveyourintimacy.com
Em: Info@evolveyourintimacy.com

Client Informed Consent, Information & Agreement

Please read, provide information as requested, and initial at the bottom of each page. This agreement is intended to provide you, the Client, with necessary information regarding our professional services and business policies. This consent form will provide a clear framework for our working relationship as mental health professionals and clients and must be filled out. If you have any concerns, please reach out to us immediately.

Services

We provide counseling and coaching to adults 18 and older individuals, couples, throuples+, and LGBTQI+ in monogamous, non-monogamous, polyamorous relationships, and those identifying as Asexual. We cover communication, conflict resolution, relationships, sexuality, sexual health, and alternative relationships. We, as professionals, try to set the tone of each session, but you set the pace. Our professionals range from Sex Therapists, Licensed Professional Counselors, Board Certified Coaches, to Certified Coaches.

Nature of Counseling | Coaching

Counseling | Coaching is the application of mental health principles through cognitive, affective, behavioral, or systemic interventions that address areas such as personal growth and mental health disorders. To maximize the benefit of your session, it is necessary to commit to the process. In addition to talking with us during your appointment, "homework" may be assigned to allow the practice of new skills and behaviors. We expect clients to be open and cooperative in the counseling process while realizing they have a choice in the treatment.

Risks of Counseling | Coaching

The goal of counseling | coaching is to increase self-awareness, which can sometimes result in increased levels of sadness, fear, anger, and related emotions that can be overwhelming. You may also learn things about yourself and your relationships that you do not like. Often, personal relationships are impacted by the new choices you make due to these new insights. Success in counseling and coaching depends on efforts made by all parties involved in the therapeutic or coaching relationship, and you are encouraged to address any goals and expectations that you feel are not being met. At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling | coaching.

(NO FURTHER ENTRIES FOR THIS PAGE)

_____ (please initial indicating your understanding & agreement)

Appointments

Appointments are made by going to our website, evolveyourintimacy.com, or calling our office phone at 254-432-5521 Monday - Friday between 9:00 AM and 6:00 PM. Weekend appointments are made as needed but are not guaranteed, and an additional $25 fee is assessed. You may leave a message anytime since we do not answer the phone during sessions. Sessions are 50 minutes (1hr), with 10 minutes used for administration. The number of sessions needed depends on many factors and will be discussed by the counselor or coach. Also, please keep in mind that if you are more than 10 minutes late for your appointment, this is considered a no-show, and you will be charged a $50.00 no-show fee for the session (see below), which must be paid in full before another appointment will be scheduled.

Professional Fees and Payments

The following is a list of service fees.

Modality of Treatment

*Prices do not reflect processing fees.

Consultation		
- Self-pay rate	(30 min)	FREE
No-Show Fee		
- You must cancel your appointment 24 hours in advance to avoid a fee.		$50.00
Therapy I Coaching		
- Self-pay rate	(60 min)	$125 ( )
+ processing fees (not shown)		$175 (Certified Sex Therapist – Dr. Stephanie)
	(90 min)	$150 (Coach)
		$225 (Certified Sex Therapist – Dr. Stephanie)
	(120 min)	$200 (Coach)
		$300 (Certified Sex Therapist – Dr. Stephanie)
Intensive Therapy		
- Self-pay rate	(600 min)	$1,000
Court Testimony/Depositions		
- Self-pay rate		$1000 (one-time, one appearance)
- Self-pay Each Additional Day		$500/day
- Self-pay Travel/Lodging		Federal Travel & Lodging Rate
Legal Document Request		
- Forms, Letters, Memoranda		$25 per requested document
Psychological Evaluations		
- Onboarding		$ 250
- Evaluation		$1,200 = $1,500* total
- Evaluation Report		$ 50
- Travel/Lodging (40+ miles from bus)		*Federal Travel & Lodging Rate
Monthly Subscription Option		
- Unlimited Text & Email		$300 per month – Coach
- 4 Sessions (60 min) per month		$600 per month – Certified Sex Therapist – Dr. Stephanie
- 15% discount on workshops		

(NO FURTHER ENTRIES FOR THIS PAGE)

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***Evolve Your Intimacy does not bill your insurance on your behalf for working with our sex therapists; however, a Superbill will be provided upon request. Additionally, Evolve Your Intimacy LLC utilizes Wix Payments as our payment system. By signing this contract, you are agreeing to be automatically charged before or after services have been rendered. Evolve Your Intimacy LLC is not responsible for errors created through Wix payment portal or system.**

Cancellations/No Shows

Cancellations should be made as soon as possible and must be at least 24 hours in advance. You are responsible for canceling your appointment online or contacting us in advance to cancel or reschedule your appointment. A no-show is when the Client does not call to cancel and does not show up for the scheduled appointment within 10 minutes of the scheduled appointment. If a client does not call, text, or email to cancel an appointment 24 hours BEFORE the scheduled session, the Client will be charged $50 for the session.

I agree to provide the following credit card information and agree to the $50.00 charge if I do not show up for a scheduled appointment if it is not canceled within 24 hours. **(Mandatory)**

Name on card _____

Credit Card Number _____

Expiration Date Month and Year_____/_____ 3 Digit Code on Back of Card _____

Zip Code for Card Billing Address _____

Printed Name_____

Signature _____ Date_____

One no-show will result in future sessions being taken off the schedule. It will then be the Client's responsibility to contact our office to schedule future appointments. Any outstanding no-show fees must be paid in full before future appointments or services are scheduled. We understand things happen that can be out of your control, which is known as EMERGENCIES. We qualify the following as emergencies with proof of occurrence:

-Hospitalization/Injury -Medical Emergency -Vehicle Accidents -Passing of a loved one -Other Legal Scenarios

If your emergency is not listed, don't hesitate to contact our office to discuss and validate. Our billing department and client specialists make all final decisions. Our therapy and coaching professionals do not have the authority to verify an emergency or waive any fees.

Email, Cell Phones, Computers and Faxes (Mandatory)

It is essential to be aware that computers, fax machines, email, and cell phone communication can be relatively easy to access by unauthorized people and could compromise the privacy and confidentiality of such communication.

Scheduling and rescheduling appointments should be done online or by calling our office at 254-432-5521 or using the secure online Client Portal. However, suppose you choose to communicate via text or email regarding the personal information. In that case, you are doing so with the understanding that these communication methods could be accessed by unauthorized people, compromising your privacy and confidentiality.

We should both realize that communication via telephone or email entails extra challenges since we cannot see body language, facial expressions, etc. Therefore, we give each other plenty of latitude and promptly ask for clarification if there is a misconnection.

Due to confidentiality & privacy, we cannot accept friend requests or connections on any social media platform during a client's treatment. Our scheduling software will contact you via text, automated phone call, or email to confirm your appointment at the phone number of your preference.

(NO FURTHER ENTRIES FOR THIS PAGE)

_____ (please initial indicating your understanding & agreement)

Phone# for contact: _____ Email Address: _____

____ Call OK ____ Email OK

____Text OK ____Voicemail OK

Telephone Accessibility

We monitor our messages left at 254-432-5521 during business hours and will make every effort to return your call within 24 hours of when you make it. If you are challenging to reach, please leave the times when you will be available. Should you have a true clinical emergency after hours or any time requiring immediate attention or action, you must call 911 or go to the nearest emergency room. The phone number listed above should NOT be used as a crisis hotline, as we are unavailable 24 hours a day.

Confidentiality/Notice of Privacy Practices

The names of clients you may contact at this office are to be kept confidential and protected by Texas and Florida Laws concerning Mental Health (Article 5561H, see 2a and 2b). As a client/parent at this office, I understand that you must comply with this confidentiality policy. Please also know that this applies to all visits from this date forward. Discussions between a counselor and a client are confidential. No information will be released without the Client's written consent unless mandated by law.

Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where the counselor must disclose, or where, in the counselor's judgment, it is necessary to warn, notify, or disclose; fee disputes between the counselor and the client; a negligence suit brought by the Client against the counselor; or the filing of a complaint with the licensing board or other state or federal regulatory authority.

If you have any questions regarding confidentiality, you should bring them to the attention of the counselor or coach when you and the mental health professional can discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned counselor to share confidential information with all persons mandated by law and with the agency that referred you, and you are also releasing and holding harmless the undersigned counselor from any departure from your right to confidentiality that may result.

In the case of couples counseling | coaching, we will keep confidential (within the limits cited above) anything that you disclose to us without your family members or partner's knowledge. However, we encourage open communication between couples, and we reserve the right to terminate our If you have any questions regarding confidentiality, you should bring them to the attention of the counselor or coach when you and the mental health professional can discuss this matter further.

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In the case of couples counseling | coaching, we will keep confidential (within limits cited above) anything that you disclose to us without your family members or partner's knowledge. However, we encourage open communication between couples and reserve the right to terminate our counseling relationship if we judge it as detrimental to the therapeutic process.

Authorization to Release Information

(Complete only if you wish to share your information with another professional, EX, a Doctor, or other Mental Health Professional)

I/We _____ (name of Client or Guardian) hereby authorize Evolve Your Intimacy LLC to release records and/or information concerning treatment dates and diagnosis to: _____

(NO FURTHER ENTRIES FOR THIS PAGE)

_____ (please initial indicating your understanding & agreement)

Duty to Warn and Duty to ACT (Mandatory)
Suppose the undersigned professional reasonably believes that you are in danger, physically or emotionally, to myself or another person. In that case, you consent for the counselor or coach to warn the person in danger and to contact any person to prevent harm to yourself or another person, in addition to medical and law enforcement personnel and the person you have identified as your Emergency Contact. This information is to be provided at our request only to prevent harm to yourself or another person. This authorization shall expire upon the termination of counseling. You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned counselor has not taken action based on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could still be permitted by law.

Emergency Contact Name: _____ Phone # _____

Counselor's | Coaches Incapacity or Death
We acknowledge that in the event the undersigned professional becomes incapacitated or dies, it will become necessary for another counselor or coach to take possession of our files and records. By signing this information and consent form, you consent to allow another licensed mental health professional, selected by the undersigned professional to take possession of your files and records and provide them with copies upon my request or to deliver them to a counselor or coach of your choice.

Client Grievance Policy
Therapists
Suppose a client becomes dissatisfied with the services provided by the counselor. In that case, the Client has the right to discuss this with the counselor and then to appeal the grievance with the Texas State Board of Examiners of Professional Counselors for all licensed professionals. Significant effort will be taken to resolve client grievances on this level promptly and mutually. The counselor hopes that the client's concerns do not disrupt services. The request for appeal to the Texas State Board of Examiners of Professional Counselors must be in writing, with such request including a brief statement of the grievance. Anyone wishing to file a complaint with the Licensing Board against a Licensed Professional Counselor may write to:

Complaints Management and Investigation Section
P.O. Box 141369
Austin, Texas 78714-1369

Coaches
Suppose a client becomes dissatisfied with the services provided by the coach. In that case, the Client has the right to discuss this with the coach and then appeal the grievance to the business that holds the certified professional within compliance. Significant effort will be taken to resolve client grievances on this level promptly and mutually. The coach hopes that client concerns do not lead to disruption in services. With such a request, please include a brief statement of the grievance. Anyone wishing to file a complaint with the Coaching Board against a Certified Coach may write to:

Evolve Your Intimacy LLC
Compliance & Grievances Dept.
100 West Central Texas Expressway, Suite 208
Harker Heights, TX 76548

If resolved on your behalf, all grievances will also be met with a refund for that session.
All practitioners must have their licensing and certification information in the profile portion of our website, which can be found at evolveyourintimacy.com. Please notify us immediately if you cannot see this information or if it is not listed.

(NO FURTHER ENTRIES FOR THIS PAGE)

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COLLECTIONS PROCESS

10 Days If your account becomes negative, you will be given 10 days to negotiate a payment schedule or pay the account in full before future appointments are scheduled or accepted. During this time, we will attempt to settle your account via email. No interest will be accrued during this period.

30 Days If your account remains negative or unpaid within 30 days, your account will be placed into an in-house debt collection process. You may negotiate a payment schedule but not receive services until your account is paid in full. We will attempt to settle your account via phone or email during this time. A $20 Late fee accrual will be added to your debt for administrative and debt collection fees.

60 Days If your account remains negative or unpaid within 60 days, your account will stay in an in-house debt collection process. You may negotiate a payment schedule but not receive services until your account is paid in full. We will attempt to settle your account via phone or email during this time. A $50 Late fee accrual will be added to your debt for administrative and debt collection fees.

90 Days If your account remains negative or unpaid within 90 days, your account will be placed into a debt consolidation process through a licensed debt collection company. You may negotiate a payment schedule but not receive services until your account is paid in full. During this time, we will attempt to settle your account via phone, email, and a certified official debt letter and request that you pay immediately. A $100 Late fee accrual will be added to your debt for administrative and debt collection fees. Additionally, you authorize an automatic ACH debit from your checking account to settle your account.

Debt Collection after 90 days: If your account remains negative or unpaid within 90 days, your account will be placed into civil action and collection process within our court of jurisdiction. You may not negotiate a payment schedule; your account will remain due immediately. Additionally, your budget and services will be terminated permanently with this practice. A third-party licensed debt Collection Company will become your point of contact, and our office will no longer be able to handle or service your account. The court will determine your final account fee, and fees will be added from the third-party debt collection company. Additionally, you authorize an automatic ACH debit from your checking account to settle your account.

AUTHORIZATION FOR ACH WITHDRAWL (Attach a voided check to this form) (Mandatory)

Customer Name: _____

Customer Address: _____

Bank Name: _____

Bank Address: _____

Routing Number: _____**Bank Checking Acct Number:** _____

I Authorize Evolve Your Intimacy LLC to withdraw funds from the account listed above in the event of a debt collection.

Print Name: _____ **Signature:** _____ **Date:** _____

Further, we follow the Texas Debt Collection Law Title 5, Chapter 392, Subchapter A, and the federal Fair Debt Collection Practices Act. Suppose you believe your account has been subject to error and you are not indebted to our practice. In that case, you may call (254) 432-5521, email us at info@evolveyourintimacy.com, or correspond by official certified letter to Evolve Your Intimacy LLC, 100 West Central Texas Expressway, Suite 208, Harker Heights, TX 76548.

(NO FURTHER ENTRIES FOR THIS PAGE)

_____ (please initial indicating your understanding & agreement)

By signing below, you acknowledge you have read and understood this agreement as it has been written and intended for the use of services with Evolve Your Intimacy LLC 100 West Central Texas Expressway, Suite 208, Harker Heights, TX 76548, **PH**: 254-432-5521 **FAX:** 432-223-9896 **Web:** evolveyourintimacy.com **Em:** Info@evolveyourintimacy.com.

Printed Name_____

Address: _____

DL#:_____ DL State: _____

Signature: _____ Date: _____

TELETHERAPY CONSENT FORM (REQUIRED IN THE EVENT TELEHEALTH IS NECESSARY)

Teletherapy is a form of therapeutic service provided via Internet technology, which can include consultation, treatment, and transfer of medical data, emails, telephone conversations, and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually. Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I know that I have the following rights concerning teletherapy:

1.. I, the Client, have the right to withhold or withdraw consent without affecting my right to future care or treatment.

2. The laws protecting my medical information's confidentiality also apply to teletherapy. As such, I understand that the information I disclosed during my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with Stephanie Sigler, LPC, CST, PhD, or any of the following mental health professionals listed on evolveyourintimacy.com

3. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my psychologist, that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my data could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. There is a risk that unforeseen technical problems could disrupt or distort services.

5. I also understand that teletherapy-based services and care may not be as complete as face-to-face services. I also understand that if my psychologist believes I would be better served by another therapeutic service (e.g., face-to-face service), I will be referred to a professional who can provide such services in my area.

6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I know that there are potential risks and benefits associated with any form of psychotherapy and that despite my efforts and the efforts of my psychologist, my condition may not improve and, in some cases, may even get worse.

7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support. Clients actively at risk of harm to themselves or others are unsuitable for teletherapy services. If this is the case or becomes the case in the future, my psychologist will recommend more appropriate services.

8. I understand there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment, and internet access

_____ (please initial indicating your understanding & agreement)

for my teletherapy sessions and (2) arranging a location with sufficient lighting and privacy-free from distractions or intrusions for my teletherapy session. The psychological treatment provider is responsible for doing the same on their end.

9. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

Consent for Services (Mandatory)

Thank you for reviewing this information, and please feel free to discuss it with me. This Client Informed Consent and Information will be updated on January 1st of each year for all existing clients and supersedes any previously signed Client Informed Consent and Information forms. My/our signature(s) on this disclosure statement indicate that I/we have read and understood the conditions of the counseling services outlined. I/we have had the opportunity to clarify any questions and agree to the terms described above before receiving services.

Client's Written Name(s): _____

Date(s) of Birth: _____

Address: _____

City/St/Zip: _____

Client/Guardian Signature _____ Date _____

Client/Guardian Signature _____ Date _____

SCAN DRIVERS LICENSE, State ID, Military ID, or Government ID card and SUBMIT TO YOUR SPRUCE HEALTH CLIENT PORTAL or attach a JPEG or PNG photo with your response.

(NO FURTHER ENTRIES FOR THIS PAGE)

_____ (please initial indicating your understanding & agreement)