

Seeds of Change Therapy

Mary Jane Hooper, MS, LMFT, CGP
Park Plaza Building
2501 Parkview Drive, Suite 305
Fort Worth, Texas 76102

PRACTICE STATEMENT

I understand that Ms. Hooper will provide the following services to me for the following fees:

Individual Therapy.....\$125.00 per session

Group Therapy.....\$50.00 per session

Family or Couples Therapy.....\$125.00 per session

Sessions, other than group, will last 50 minutes. Every effort will be made to begin and end on time.

80 minute sessions.....\$175.00 per session

I have discussed my goals for therapy with Ms. Hooper. I understand that therapy is a joint effort between the therapist and client. I understand that it is a multi-level process and involves more than eliminating my initial concerns. As a learning process, it takes time and will require an active effort on my part. After identifying my goals, I will seek to transform areas of my life that no longer serve me. To progress in creating the life I desire, I will outline internal as well as external motivations for change.

1. _____

2. _____

3. _____

4. _____

5. _____

I understand that the information I provide Ms. Hooper is confidential and will be released to others only by my written consent. I have been informed that the therapist is required by law to disclose confidential information without my consent in certain circumstances which include the following: If I am evaluated to be a danger to myself or others, if I am a minor, elderly or disabled and the therapist believes I am the victim of abuse or if I divulge information about such abuse, if I file suit against the therapist for breach of duty, and if a court order or legal proceeding requires disclosure, I will have the opportunity to ask Ms. Hooper any questions I may have on the limits of confidentiality

I understand that Ms. Hooper is available for telephone contacts between sessions, on an as needed basis. Anything over five minutes will be prorated. I understand that the sessions can be canceled by calling the number, 817-348-8222, on a 24 hour basis. If I fail to give 24 hour notice, I will be expected to pay \$125.00 per missed appointment.

Acknowledgments and Consent:

I understand and have read the above consent to psychotherapy with Ms. Hooper.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____