

**Cressan Smith, MS, LPC**  
214-679-1233

6750 Hillcrest Plaza Dr., Suite 304  
Dallas, Tx 75230

18601 LBJ Fwy, Suite 711  
Mesquite, TX 75150

**INFORMED CONSENT**

I/we, \_\_\_\_\_, the undersigned, hereby grant permission for therapy to be conducted by Cressan Smith. I/we understand that the therapy sessions and records are strictly confidential except where the state law requires the reporting of threats of violence, harm, or child abuse and neglect (from suspicion or evidence), and when information is subpoenaed by the courts or officers of the court.

\_\_\_\_\_ initial

The standard fee for a 45-minute therapy session is \$120.00 cash, check, or credit card. All fees are payable on the date of service. I/we accept financial responsibility for charges I/we incur during the course of treatment. (Many insurance companies cover LPC services. Services received from Cressan Smith, LPC would be considered out of network. I/we are responsible for checking with our insurance benefits to see if out-of-network services are covered and to file claims.)

\_\_\_\_\_ initial

**I/we agree to give at least 24 hours advance notice if unable to keep an appointment. I/we understand that there is a service charge of \$60.00 for missed appointments not canceled 24 hours in advance.** I/we understand that failure to show for any scheduled appointment, and/or calling to cancel after the actual time of the appointment, will be documented as a no-show. I/we understand that 2 no-shows will result in chart closure.

\_\_\_\_\_ initial

I/we understand that results or outcomes from the therapy process cannot be guaranteed. I/we understand that I/we can question any therapeutic approach utilized at any time. If I/we decide to terminate therapy, I/we will discuss termination with the therapist.

\_\_\_\_\_ initial

Complaints can be filed with the Texas State Board of Licensed Professional Counselors at 512-834-6658.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date