



Michael Meister, LPC, LPCC (#5531, #4602)  
Licensed in Oklahoma and California  
[www.meistercounseling.com](http://www.meistercounseling.com)

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### **INDIVIDUAL COUNSELING INFORMATION, FEES, AND GUIDELINES**

Counseling is a collaborative endeavor requiring mutual commitment and participation. Counseling involves the willingness to look again, with fresh eyes, at yourself and the changes that you maybe seeking. Counseling provides a tremendous opportunity for growth, internal change and evolution. One of the models that I use views struggles that individuals inevitably experience are a normal and necessary part of the human drive for psychological wholeness and change. In this work you will be asked to practice and develop the following:

- An on-going willingness to feel, identify, describe, and express aspects of yourself.
- The willingness to be open to your own inner experiences.
- The willingness to regulate your emotional experiences with your inner self.

These can be difficult skills, as they may be new to you. They require courage and perseverance to practice. With this in mind, I will share experience, tools, and ground rules that enhance emotional safety.

I offer the following information with a commitment to clarity and to create conscious agreements in our shared venture. It is designed to provide broad guidelines to our collaboration, as well as, to address specific situations should they arise. Please review and sign below only when all is clear and

agreeable to you. I welcome your response and questions. I encourage you to discuss them with me.

**Confidentiality:** Strict confidentiality applies to information you share with me in session or phone contact except where limited by law. In the event I believe that you may harm yourself or another, or if I become aware of the occurrence of child or elder abuse, I am required by law to make a formal report to the appropriate agencies. If you wish for me to exchange or provide information to others concerning your well being, I will need a written release of information signed by you.

**Fees:** My fee for individual counseling is \$140.00 per 50-60 minute session. I do offer a sliding scale for those with hardship circumstances. The sliding scale is on a case-by-case basis. Longer sessions are available by arrangement and pro-rated on an agreed upon fee. Payment is due at the beginning or end of each session unless special arrangements have been made in advance. I keep records of your account and can provide billing receipts upon request. \*\*\* Fees are subject to change and you will be notified in advance of any changes made to my fee structure.

**Punctuality:** If you are late and I have not received notification from you, I will wait for 10 minutes before assuming that you are not keeping your appointment. Otherwise, we will proceed when you log on and will end after the 50-60 minutes. I understand that sometimes we all run late to appointments and that is why I try to be as flexible as I can be. However, if there is a pattern of tardiness we will then end at the usual time from the time that you arrive.

**Canceled/missed appointments:** Please give 24 hours notice if you need to cancel a session. You can cancel online or by emailing me prior to the scheduled session. If you are unable to keep an appointment without 24 hours notice, the usual fee will be charged except in the case of an extreme emergency.

**Phone calls/texts/emails:** If you need to reach me prior to the session you can do so by email or phone. Text is okay too. My phone number is 480-326-1770. I check my email and phone consistently. My email is [mjmmeister@gmail.com](mailto:mjmmeister@gmail.com).

**Disclosure of Credentials:** I am required by the state of Oklahoma to disclose to you my credentials. I have a master's degree in counseling psychology. Furthermore, I am a Licensed Professional Counselor and am licensed by the state of Oklahoma to practice psychotherapy. I am also licensed as a Licensed Professional Clinical Counselor in the state of

California. If you have any questions about the license or my credentials please feel free to ask me at anytime.

**Conclusion:** The length of time we will work together depends upon your goals, life situations, and pace of our work. Ultimately you are the best judge of when the process is complete enough to end counseling. With that being said, you, as the client, have the right to terminate counseling at any time. I look forward to working with you and assisting you in living the life that you deserve and want for yourself. Please sign acknowledging that you understand my practice policies. Please print out and keep a copy for your records as well.

My signature below indicates that I have read and understood the following policies and informed consent presented before me:

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date



### Telehealth informed consent

I, \_\_\_\_\_, agree to participate in teletherapy with Michael Meister, a licensed professional counselor and licensed professional clinical counselor.

This means that:

I understand that I will be informed of the identities of all people who are present during the teletherapy session and informed of their purpose for attending the session.

Michael Meister (LPC,LPCC) has explained how the teletherapy system works and how it will be used for my treatment.

Michael Meister (LPC,LPCC) has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.

I understand that Michael Meister (LPC,LPCC) will not be physically present during my teletherapy session. Instead, we will see each other electronically.



I understand that teletherapy is an evolving modality for therapy. As such, there may be potential risks that may not yet be recognized.

Potential risks include: a) at times video image may be unclear or inadequate, b) a disruption in the connection may occur, or c) in rare circumstances, the information may be intercepted by unauthorized persons.

I understand that at any time, I may decide to discontinue teletherapy sessions with Michael Meister (LPC, LPCC). If so, Michael Meister will refer me to a local mental health provider who can provide face-to-face services.

I agree to take every precaution to preserve the confidentiality of my sessions, such as ensuring that calls are taken in a safe and secure location to the extent possible.

I understand that, under the law, Michael Meister (LPC, LPCC) may be required to report to authorities any information suggesting that I have engaged in behaviors that are dangerous to myself and others.

Michael Meister (LPC, LPCC) has explained the risks and benefits of receiving teletherapy. I understand that I may need to see a specialist in person.

I understand that information from my teletherapy session will be protected by HIPPA privacy laws. I may request a copy of my electronic record in writing.

The contact information for this provider is:

Michael Meister, LPC, LPCC

[mjmmeister@gmail.com](mailto:mjmmeister@gmail.com)

480-326-1770

I voluntarily consent to participate in telemental health services using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_



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[mjmmeister@gmail.com](mailto:mjmmeister@gmail.com)

**\*\*\*IT IS POLICY OF THIS OFFICE TO KEEP DEBIT/CREDIT CARD ON FILE. YOU MAY PAY BY CASH OR CHECK, BUT CARD MUST STILL BE KEPT ON FILE\*\*\***

**Name on Card:**

\_\_\_\_\_  
**I authorize Michael Meister, LPC (Meister Counseling) to charge my credit/debit card for professional services as follows:**

\_\_\_\_\_ **All visits for which payment was not made at time of visit.**

\_\_\_\_\_ **To charge my card the regular session fee for each no-show or late cancellation (less than 24 hour noticed per informed consent and cancellation policy agreement.)**

Type of card: Check one of the following:

\_\_\_\_\_ Visa

\_\_\_\_\_ Mastercard

\_\_\_\_\_ Discover

\_\_\_\_\_ AMEX

Credit card number: \_\_\_\_\_

CVV Number (on back of card) \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Card Holders Billing Address: \_\_\_\_\_

\_\_\_\_\_

**Card Holder Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

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### **Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

### **Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

### **Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

### **Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

### **Insurance Providers (when applicable)**

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

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Client Signature (Client's Parent/Guardian if under 18)

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Today's Date



## CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

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Client Signature (Client's Parent/Guardian if under 18)

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Today's Date