

# **Linda Brase, M.A, LPC-Intern**

Supervised by Candyce Ossefort-Russell, LPC, PLLC  
2124 Bluebonnet Lane, Austin, TX 78704  
512.789.6244

8017 Mesa Drive, Suite 102

Austin, Texas 78731

512.496.4848

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## **Informed Consent Agreement**

This form explains aspects of how I work. I encourage you to ask any questions you have about my way of working or about psychotherapy in general at any point in our therapy together.

### **Training and Background**

I am a Licensed Professional Counselor Intern, licensed by the Texas State Board of Examiners of Professional Counselors, and I am working under the supervision of Candyce Ossefort-Russell. Contact information for Candyce is as follows: Candyce Ossefort-Russell, LPC, PLLC, 2124 Bluebonnet Lane, Austin, TX 78704. Telephone: 512.789.6244.

I received my M.A. in Counseling, with an emphasis in Medical Crisis Counseling, from St. Edward's University in Austin, Texas. I have completed additional training and/or internships with Capital Area Mental Health Center (training in long-term therapy), Wonders and Worries (specializing in helping children and families cope with chronic or life-threatening illness), and Hospice Austin (regarding bereavement and end-of-life issues).

### **Confidentiality**

I will treat with great care all information you share with me. It is your right that our sessions and my records about you be kept private. In all but a few rare situations, your confidentiality is protected by state law, the rules of my profession, and my personal integrity. Texas state law requires me to inform you that in certain cases your confidentiality is not protected, and your information may be disclosed to the appropriate authorities/agencies. These cases are:

- If I have reason to believe that you may harm yourself or others,
- If I have reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability, or
- If I am ordered to disclose by state or federal courts.

Additionally, I may disclose information if you sign a release form granting permission to designated third parties to receive information that you request me to share.

I will never disclose your information for any reason without your knowing of my intent.

## **Therapeutic Relationship**

The relationship between therapist and client is the container through which change can take place. As such, the relationship is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. Because the therapist-client relationship is so important, I cannot be involved in a social relationship or friendship that exists outside of the therapy room. Limiting our relationship to the therapy office keeps your therapeutic environment safe, secure, and free of outside complications that could interfere with your therapy work.

## **The Therapeutic Process**

In my view, working with clients entails tailoring therapy to meet the needs of each client individually. I have worked with clients experiencing grief, financial difficulties, relationship difficulties, and those who are alone without family support. My approach to therapy is that it is a way of being (as opposed to a set of techniques) and each client's human nature is viewed in a positive light incorporating the belief that people naturally move toward becoming fully functioning.

While not all of the therapy may meet your expectations, and your symptoms may become more pronounced at different points during the course of therapy, therapy is hopeful work. Much of the work can ultimately help with shifting your inner perspective in a healthy way, which assists in dealing with painful feelings, making sense of difficult memories, or resolving problems in relating to others.

My experience with a life-threatening illness greatly influenced my approach to therapy. Working with clients dealing with a cancer diagnosis or chronic illness has become one of my passions. Distress is a natural result of a medical crisis and even the most mentally healthy individuals face serious psychological challenges.

Whatever the issue, the work is based on the assumption that therapy paves the way for clients to utilize their innate capacity to create solutions for themselves. It is my lifelong mission, a privilege, and an honor to work with clients along their journey to true happiness and health.

## **Fees**

My fee is \$65 per 50-minute session. Payment in full is due at the time services are rendered, unless you make special arrangements with me beforehand. Please make checks payable to “**Candyce Ossefort-Russell.**”

Because I respect the integrity of therapy sessions, fees must be paid at the beginning of each session. When checks are written at the end of a session, the momentum of the session can be derailed.

**Session Guidelines**

I hold 50 minute sessions. If you need to cancel an appointment, you must give me 24 hours notice. Otherwise you will be charged for the missed appointment.

Sessions are expected to begin and end at the scheduled time. Late arrival on your part will not extend the scheduled ending time for a session. I am also expected to be on time, and I will make appropriate remedy if I am late, such as by making up the time, prorating the fee, etc.

The frequency of sessions and the length of the psychotherapy are aspects of the work that you and I will decide together as we proceed. Generally, our psychotherapy will continue until you and I together decide that our work is complete.

**Outside Contact and Emergencies**

You may leave a message for me on my private, confidential voice mail (496.4848) at any time. I check my messages daily, and I will return your call as soon as I can. However, this number is not an emergency phone number.

In case of an emergency, or if you need immediate assistance for any reason, please call the 24-hour crisis hotline at **472-HELP (472-4357)**.

Again, please feel free at any time to ask me any questions you may have about the information outlined in this or any of my other forms.

I have understood and received a copy of this agreement.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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Signature of Therapist

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Date