**Joseph D. Hayes MS,LPC,NCC.**

881 FM 2882, Mount Pleasant Texas 75455

(903) 285-5121 or fax 1-888-257-6008

**Counseling Treatment Style and Expectations**

1. **No guarantee of any positive outcome is made about my counseling services.** Mr. Hayes has an eclectic approach that is heavily Gestalt influenced. This treatment model maybe a little more confrontational than other counseling models. This model believes the relationship between the client & counselor is formed by being genuine with the goal of becoming aware of thoughts, feelings, decisions with logical consequences & perceptions. There for this model may not be a good counseling fit for clients looking for support & comfort treatment. Although I will make effort to support a client’s feelings, confrontation may make this treatment not desirable to clients who are just seeking support or are fragile in their personal outlook & views. The approach is one that seeks awareness in life, self, and behaviors. Some people prefer a more direct treatment than just supportive listening If this treatment is not working for you, I as the counselor expect you to bring it up in treatment discussion & a referral to a different therapist may be in your best interest. This applies to both individual and couples in counseling.
2. Couples Counseling clients expected to be **open about all situations, with no secrets** held from their partners. That means both parties will know all interactions with the therapist by the partner. (I.E Not recommended, but in the past a client had sent a recording of their partner blowing up being verbally abusive. I would immediately address this issue when the next session begins, with no secrets withheld. So, if you enter couple counseling, you enter with full transparency of both partners.
3. Please do not text me, message on Face book or email me anything other than appointments or cancellations. I cannot guarantee texting, messaging, or emailing is confidential, so please just call to set appointments. You may leave a confidential voicemail on my cell (903) 285-5121 & I will return your call.
4. Please make sure you have a contact phone number, one where if I call or text you, you can get back to me within a timely manner. I have diabetes and may need to cancel appointment, or I may get a call from your insurance and need further information.
5. **You agree to not record counseling sessions in any form or fashion.**
6. Social Media I do not consider real life and usually accept friend requests from most everyone. Now if you are friends with me on my Facebook social media, then you agree to unfriend me. If I catch it, I will unfriend any client. I will not accept friend request for duration of treatment and then not till 2 years after therapy is complete per ethics**. Please do not post on my Facebook account!**
7. Mr. Hayes does have diabetes, asthma, gout, and high blood pressure. This is alerting you that he may need to reschedule occasionally. If this is of concern, please indicate so he can refer you to another practitioner.
8. You are responsible for scheduling appointments & adhere to treatment plan. If a no-show happens, then you must contact the therapist & reschedule. If you do not reschedule an appointment in 90 days, your treatment will be terminated & case will be automatically discharged with referral to Lakes Regional MHMR, (903) 572-8783.
9. If you or someone on your behalf sends a request for records, subpoena, or any legal issues arise while I am treating you, then I will immediately terminate treatment and refer out as I have communicated, I do not want involved in any legal proceedings of any nature. I believe such actions would hamper my ability to continue a therapeutic relationship. By signing, you the client is demonstrating understanding & agreement, thereby if you do not agree with any forms**, DO NOT SIGN THEM**.

**Client agrees, accepts conditions & demonstrates understanding by signing in person or electronically this form. The client understands all conditions, risks & expectations of treatment and acknowledges all forms presented to client to be agreed upon and understands all risks of entering treatment.**

**Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**