

**Therapeutic Connections Counseling Services, PLLC**  
**Erika Meek, M.Ed., LPC, NCC**  
3550 Parkwood BLVD Suite A-201, Frisco, Texas 75034  
Phone: (214)797-7961 Fax: (469)287-4107

**Welcome to my office! I thank you for making your first appointment and I look forward to working with you. I would ask that you review and sign this paperwork, where indicated. Please bring all signed paperwork and a copy of your drivers license and current insurance card (if you are having Erika Meek, M.Ed., LPC, NCC file claims with your insurance company).**

**Respectfully,**  
**Erika Meek, M.Ed., LPC, NCC**

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**Child Information**

**Child’s Legal Guardian Managing Conservator:** if the child is not living with both natural parents, both adoptive parents, or only living parent, this practice requires **a photocopy of the most recent legal document stating custody arrangements. Services will NOT be rendered if no copy is produced.**

Please initial that you have read and understand this paragraph \_\_\_\_\_

Child’s First Name: \_\_\_\_\_ Child’s Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Home phone: \_\_\_\_\_ Is it ok to leave a message? \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of person responsible for payment: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_

Parents have: \_\_\_\_\_ Joint Custody \_\_\_\_\_ Mother has custody \_\_\_\_\_ Father has custody

\_\_\_\_\_ Other has custody: \_\_\_\_\_ Can you provide legal documentation? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Parent/Guardian Information**

**Mother**/Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Is it ok to leave a message? \_\_\_\_\_ Yes \_\_\_\_\_ No

Email Address: \_\_\_\_\_ Is it ok to leave a message? \_\_\_\_\_ Yes \_\_\_\_\_ No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Length of Employment: \_\_\_\_\_

Marital History and Status:  Never Married  Currently Married  Divorced  
 Widow Number of Marriages: \_\_\_\_\_ Number of Divorces: \_\_\_\_\_

History of emotional/mental health related issues:  Yes  No

If yes, please explain: \_\_\_\_\_

History of behavioral/ conduct problems:  Yes  No

If yes, please explain: \_\_\_\_\_

History of Suicide Attempts:  Yes  No

If yes, please explain: \_\_\_\_\_

History of inpatient psychiatric care:  Yes  No

If yes, please explain: \_\_\_\_\_

History of addiction:  Yes  No

If yes, please explain: \_\_\_\_\_

History of family violence:  Yes  No

If yes, please explain: \_\_\_\_\_

**Father**/Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Is it ok to leave a message?  Yes  No

Email Address: \_\_\_\_\_ Is it ok to leave a message?  Yes  No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Length of Employment: \_\_\_\_\_

Marital History and Status:  Never Married  Currently Married  Divorced  
 Widow Number of Marriages: \_\_\_\_\_ Number of Divorces: \_\_\_\_\_

History of emotional/mental health related issues:  Yes  No

If yes, please explain: \_\_\_\_\_

History of behavioral/ conduct problems:  Yes  No

If yes, please explain: \_\_\_\_\_

History of Suicide Attempts:  Yes  No

If yes, please explain: \_\_\_\_\_

History of inpatient psychiatric care:  Yes  No

If yes, please explain: \_\_\_\_\_

History of addiction: \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain: \_\_\_\_\_

History of family violence: \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain: \_\_\_\_\_

**Insurance Information**

\_\_\_\_ Check here if other financial arrangements have been made and Erika Meek, M.Ed., LPC, NCC will not be filing claims on your behalf.

***If insurance information is being provided, a valid insurance card and a valid Government picture I.D. must be provided prior the initial intake session. The name on the insurance card must match the name on the I.D. or proof of any name changes must be provided.***

Name of Insured: \_\_\_\_\_ Date of birth of Insured: \_\_\_\_\_

SSN of Insured: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Behavioral Health Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Claims Address: \_\_\_\_\_

**Social/ Family Information**

Please list below any individuals living with the child (primary and secondary households):

Name	Sex	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Currently involved in a custody dispute? \_\_\_\_ Yes \_\_\_\_ No; If Yes, please explain: \_\_\_\_\_

If divorced, mark which best describes your relationship with your ex-spouse: \_\_\_\_ Hostile \_\_\_\_ Maddening  
\_\_\_\_ Frustrating \_\_\_\_ Friendly \_\_\_\_ Great When did divorce occur? \_\_\_\_\_

Describe the visitation schedule: \_\_\_\_\_

I UNDERSTAND THAT I MUST PROVIDE ERIKA MEEK, M.ED., LPC, NCC WITH THE MOST CURRENT COURT PAPERS REGARDING CUSTODY ARRANGEMENTS. INITIALS \_\_\_\_\_

**Medical/ Mental Health History Information**

Is your child currently receiving counseling elsewhere? \_\_\_\_ Yes \_\_\_\_ No

Is your child currently receiving psychiatric services? \_\_\_\_ Yes \_\_\_\_ No; if yes, please include name of professional: \_\_\_\_\_

Has your child been hospitalized for mental health concerns? \_\_\_\_ Yes \_\_\_\_ No; if yes, reason for hospitalization, when and where: \_\_\_\_\_

Is your child currently being treated by a physician for any medical conditions? \_\_\_\_ Yes \_\_\_\_ No; if so, please describe: \_\_\_\_\_  
\_\_\_\_\_

Is your child currently taking prescription, over-the-counter or herbal medication? \_\_\_\_ Yes \_\_\_\_ No; if so please list: \_\_\_\_\_

**Risk Assessment**

In the last 48 hours has your child reported any thoughts of harming themselves or other(s)?  
\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Self \_\_\_\_ Other(s)

Has your child ever been suicidal? \_\_\_\_ Yes \_\_\_\_ No; if yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever engaged in self injurious behaviors (cutting, burning, skin picking, scratching)?  
\_\_\_\_ Yes \_\_\_\_ No; If Yes, please explain \_\_\_\_\_

Are there any guns or weapons in your house? (specify whose and what type): \_\_\_\_\_  
\_\_\_\_\_

Has a family member or close friend ever committed suicide? \_\_\_\_ Yes \_\_\_\_ No, if Yes, Who? \_\_\_\_\_  
\_\_\_\_\_

Is there any family history of mental illness or substance abuse? \_\_\_\_ Yes \_\_\_\_ No; if Yes please list relationship and diagnosis: \_\_\_\_\_  
\_\_\_\_\_

Do you have any reason to believe your child is using any substances? \_\_\_\_ Yes \_\_\_\_ No; if yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Is there any personal history of: Physical abuse \_\_\_\_ Yes \_\_\_\_ No, Sexual abuse \_\_\_\_ Yes \_\_\_\_ No,  
Emotional abuse \_\_\_\_ Yes \_\_\_\_ No Has any abuse been reported to authorities? \_\_\_\_ Yes \_\_\_\_ No; If Yes  
please explain \_\_\_\_\_  
\_\_\_\_\_

Do you have any reason to believe that your child is sexually acting out or engaging in high risk sexual behavior?  
\_\_\_\_ Yes \_\_\_\_ No; If Yes please explain \_\_\_\_\_

Has your child ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation?)  
If so please state under what circumstance: \_\_\_\_\_

**Education**

Child's current school: \_\_\_\_\_

Teacher(s): \_\_\_\_\_

Has your child met with the school counselor? \_\_\_\_ Yes \_\_\_\_ No

School problems: \_\_\_\_ Academic problems \_\_\_\_ Discipline Problems \_\_\_\_ Social Problems

\_\_\_\_ Other: \_\_\_\_\_

What complaints does your child have about school: \_\_\_\_\_

Is your child receiving special education services? \_\_\_\_ Yes \_\_\_\_ No; If Yes, please explain: \_\_\_\_\_

Has your child ever been tested/assessed through the school district? \_\_\_\_ Yes \_\_\_\_ No; ***If Yes, please bring a copy of the results for the counselor to review.***

**Behavioral/Emotional**

Please check any of the following that are typical for your child:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Trouble with friends    | <input type="checkbox"/> Frustrated Easily        | <input type="checkbox"/> Sad                    | <input type="checkbox"/> Aggressive        |
| <input type="checkbox"/> Selfish                 | <input type="checkbox"/> Refusing to go to school | <input type="checkbox"/> Guilt/shame            | <input type="checkbox"/> Fearful           |
| <input type="checkbox"/> Separation Anxiety      | <input type="checkbox"/> Angry                    | <input type="checkbox"/> Hallucinations         | <input type="checkbox"/> Sets Fires        |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Head Banging             | <input type="checkbox"/> Poor Appetite          | <input type="checkbox"/> Panic Attacks     |
| <input type="checkbox"/> Sexual Acting Out       | <input type="checkbox"/> Hopelessness             | <input type="checkbox"/> Excessive Masturbation | <input type="checkbox"/> Running away      |
| <input type="checkbox"/> Bedwetting              | <input type="checkbox"/> Hurts Animals            | <input type="checkbox"/> Sick Often             | <input type="checkbox"/> Blinking/Jerking  |
| <input type="checkbox"/> Imaginary Friends       | <input type="checkbox"/> Short Attention Span     | <input type="checkbox"/> Bizarre Behavior       | <input type="checkbox"/> Impulsive         |
| <input type="checkbox"/> Shy, Timid              | <input type="checkbox"/> Bullies, Threatens       | <input type="checkbox"/> Irritable              | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Careless, Reckless      | <input type="checkbox"/> Lazy                     | <input type="checkbox"/> Slow Moving            | <input type="checkbox"/> Chest Pains       |
| <input type="checkbox"/> Learning Problems       | <input type="checkbox"/> Soiling                  | <input type="checkbox"/> Clumsy                 | <input type="checkbox"/> Lies Frequently   |
| <input type="checkbox"/> Speech Problems         | <input type="checkbox"/> Trouble with Authority   | <input type="checkbox"/> Listens to Reason      | <input type="checkbox"/> Steals            |
| <input type="checkbox"/> Skin picking/Scratching | <input type="checkbox"/> Stomach Aches            | <input type="checkbox"/> Cyber Addiction        | <input type="checkbox"/> Low Self Esteem   |
| <input type="checkbox"/> Suicidal Threats        | <input type="checkbox"/> Defiant                  | <input type="checkbox"/> Suicidal Attempts      | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Moody                   | <input type="checkbox"/> Talks Back               | <input type="checkbox"/> Nightmares             | <input type="checkbox"/> Phobias           |
| <input type="checkbox"/> Sibling Problems        | <input type="checkbox"/> Gang involvement         | <input type="checkbox"/> Thumb Sucking          | <input type="checkbox"/> Dizziness         |
| <input type="checkbox"/> Tics or Twitching       | <input type="checkbox"/> Oppositional             | <input type="checkbox"/> Eating Disorders       | <input type="checkbox"/> Withdrawn         |
| <input type="checkbox"/> Over Active             | <input type="checkbox"/> Over Weight              | <input type="checkbox"/> Weight Loss            | <input type="checkbox"/> Worries           |
- \_\_\_\_ Other behavioral concerns: \_\_\_\_\_

**Developmental History**

Please indicate if the below events were "normal" or "abnormal." Please describe any significant events.

**Physical:**

- Pregnancy, delivery, feeding, sleeping pattern, weaning, neonatal illnesses: \_\_\_\_\_  
\_\_\_\_\_
- Neuromuscular development of speech, motor milestones (sitting, standing, walking, first words, play)  
\_\_\_\_\_

**Behavioral:**

- Toilet training and other training- response to discipline and methods used: \_\_\_\_\_  
\_\_\_\_\_
- Reactions to beginning daycare or school: \_\_\_\_\_
- Phobias/ recurring fears: \_\_\_\_\_
- Habits/ repeated issues (bedwetting, hair pulling, picking, thumb-sucking): \_\_\_\_\_  
\_\_\_\_\_

**Social Adjustment**

- Age appropriate peer relationships: \_\_\_\_\_
- Age appropriate social etiquette: \_\_\_\_\_
- Age appropriate involvement to organized groups: \_\_\_\_\_

**Stressors Related to the Child**

Please identify if any of the following are a current or past stressor for your child. Please indicate approximate age at the time the stressor occurred and a brief description.

- \_\_\_ Chronic illness of family member: \_\_\_\_\_
- \_\_\_ Family member absent: \_\_\_\_\_
- \_\_\_ Family members disability/major accident: \_\_\_\_\_
- \_\_\_ Family members emotional problems: \_\_\_\_\_
- \_\_\_ Family members suicide: \_\_\_\_\_
- \_\_\_ Parents divorced: \_\_\_\_\_
- \_\_\_ Death of a pet: \_\_\_\_\_
- \_\_\_ Sexual assault: \_\_\_\_\_
- \_\_\_ Other traumatic experiences: \_\_\_\_\_  
\_\_\_\_\_

**Counseling Services**

What are the issues for which you are currently seeking counseling assistance? Please describe: \_\_\_\_\_  
\_\_\_\_\_

What would you like to change about the situations? \_\_\_\_\_  
\_\_\_\_\_

What have you done to cope with or resolve these issues? \_\_\_\_\_  
\_\_\_\_\_ Helpful? \_\_\_ Yes \_\_\_ No

What are some of your child's coping skills? \_\_\_\_\_

What are some of your child's personal strengths? \_\_\_\_\_

What are some of the goals you wish to address or achieve in counseling?

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_

By signing below, I confirm that the above information is true and correct. I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision **prior** to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. I understand that I have the right to agree to, or to refuse mental health services provided by Erika Meek, M.Ed., LPC, NCC.

My signature below indicates that I am the legal parent/guardian and I have the right to consent to mental health treatment. My signature below indicates my desire and consent for my child, \_\_\_\_\_  
(Child's Name)

to receive mental health services from Erika Meek, M.Ed., LPC, NCC at Therapeutic Connections Counseling Services, PLLC.

\_\_\_\_\_  
 Printed Name of Client

\_\_\_\_\_  
 Signature of Party Financially Responsible/Parent/Guardian      \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Therapist's Signature      \_\_\_\_\_  
 Date

**Therapeutic Connections Counseling Services, PLLC**  
**Erika Meek, M.Ed., LPC, NCC**  
**INFORMED CONSENT**

Before you start counseling there are some things that you ought to know. Legally, this information is called "*Informed Consent*." *Informed Consent* will help you understand better what to expect from your effort at our office, and it will explain some limitations to what we will be doing. **PLEASE INITIAL AFTER EACH SECTION TO CONFIRM THAT YOU HAVE READ AND UNDERSTAND THE PROVIDED INFORMATION.**

**Confidentiality:** Of course, all of our work together, our conversations, your records, and any information that you give us is protected by something called *privilege*. That means that the law protects you from having information about you given to anyone without your awareness and permission. Our office respects your privacy, and we intend to honor your *privilege*. However, there are some limits to your privilege, some legal exceptions you should understand before we start.

If we believe there is a risk that you might harm yourself or someone else, we may be required to contact the authorities or the other person to give them the opportunity to protect you or the other person. If we have cause to believe that you are abusing children or elderly or disabled people, we are required by law to notify the authorities. Also, if you become involved in any lawsuit in which you claim mental health is an issue, for example, a custody dispute or an injury lawsuit in which you claim compensation for emotional pain or suffering, then the court or the lawyers may insist upon, and may obtain your information from us. Similarly, you would lose the protection of your privilege if you file lawsuit against our office or a complaint with the state licensing board.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. **INITIAL** \_\_\_\_\_

**Records:** All of our communications become part of the clinical record. Records are property of Erika Meek, M.Ed., LPC- Therapeutic Connections Counseling Services. If records are subpoenaed, this does not indicate an automatic release of records and we may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the child's best interest. **INITIAL** \_\_\_\_\_

**Services and Office Policies:** Clients are seen by appointment only. Sessions will usually last 45-50 minutes, unless more time is agreed upon in advance. If you wish to change your appointment or cancel, please give at least 24 hours notice. Allowances will be made for emergencies, but be mindful that you **may be charged full fee for missed appointments**. Erika Meek, M.Ed., LPC, NCC offers individual and family counseling services and uses the CBT (Cognitive Behavioral) and Individual Psychology (Adlerian) treatment modality. Play therapy services are utilized for children ages 4-12 years. **Erika Meek, M.Ed., LPC, NCC does not conduct comprehensive evaluations for custody disputes or sexual abuse.** **INITIAL** \_\_\_\_\_

This agreement for services will remain effective until ended by agreement between you and Erika Meek, M.Ed., LPC, NCC or you inform the counselor of your decision **prior** to your last visit. If you have missed a scheduled visit and you do not call our office within *seven days*, Erika Meek, M.Ed., LPC, NCC will accept that as your notice that you have terminated this agreement and that you wish to discontinue counseling services. **INITIAL** \_\_\_\_\_



Our office does not allow counselors to accept gifts from clients or family members of clients. Counselors are not allowed to purchase goods and/or services from clients or family members. Counselors are not allowed to attend any social events or ceremonies by or for the client. If by chance, a counselor sees a client in the community, the counselor will not acknowledge or approach the client in order to respect privacy and confidentiality.

**INITIAL** \_\_\_\_\_

Clients may contact Erika Meek, M.Ed., LPC, NCC via phone or email. Text messaging may be used to cancel appointments, reschedule appointments, or to notify the counselor that the client will be late to session. Erika Meek, M.Ed., LPC, NCC will not provide counseling services, guidance or consultation via text messaging.

**INITIAL** \_\_\_\_\_

**Session Fees:** The **initial session fee is \$150** and then **each session will be \$125**, unless we have agreed upon insurance coverage or have made other arrangements. Payment is due at the time of service. No refunds are given. You are responsible for any authorization, fees or co-pays at each visit. A sliding scale fee is available for clients not using insurance based on client income and application approval. **I accept checks, credit cards, and cash payments.** I will provide you a receipt for third party reimbursement, if requested.

*Returned checks that are written to Erika Meek, M.Ed., LPC, NCC that are not honored by your bank for any reason will result in a \$25 NSF charge.*

**INITIAL** \_\_\_\_\_

**Other Fees:** While sessions are not conducted by phone, if an emergency phone consultation is initiated by the client, the first 10 minutes are at no charge. However, \$25.00 will be billed to your account for each subsequent 15-minute period. If you, or someone else needs a copy of your file or of other records that may be legally necessary, our office charges \$.25 per page for copying, plus postage.

**INITIAL** \_\_\_\_\_

**No Show and Late Cancel Appointments:** All appointments must be cancelled **24 hours in advance.** Same day cancellations or no show to appointments will incur a \$50 fee. This policy is not meant to be punitive, but appointment times you schedule are reserved for you at the exclusion of others who may be waiting to see the therapist. Insurance cannot and will not be billed for these charges. If a client is more than 20 minutes late to a session, the session will be considered a no show and the client will need to reschedule the appointment. For after hour emergencies please call 911 or the suicide hotline 1-800-237-Talk or go to your nearest emergency room.

**INITIAL** \_\_\_\_\_

Erika Meek, M.Ed., LPC, NCC is here to help you, though is in no way held liable for self-inflicted harm, harm to self, suicide, and other acts of depression or anger. By signing the policies you do not hold Erika Meek or business liable for you or your behaviors. I understand that Erika Meek, M.Ed., LPC, NCC has a duty to warn. Below is a list of people (but not limited to) that she can contact in order to help prevent harm.

**INITIAL** \_\_\_\_\_

Name	Phone	email
<hr/>		
<hr/>		

**What to expect in Counseling:** You should know that counseling is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate problems, but sometimes, especially at first, and as you

get to the root of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel awkward or uncomfortable. Sometimes counseling requires trying new ways of doing things. You will always be free to move at your own pace, however. We will challenge you and your old ways of thinking and doing things, but we cannot offer any promise about the results of the experiences. Your outcome in counseling will depend upon many things. INITIAL \_\_\_\_\_

**Commercial Insurance Carriers:** Erika Meek, M.Ed., LPC, NCC will file claims on your behalf of the Primary, In-Network insurance carrier you provide. Out of Network insurance claims are also available to be filed by our office. You understand that you are ultimately responsible for any therapy fee(s) not covered by your insurance carrier. Co-pays and any non-covered services are payable at time of service. Court fees will not be filed with your insurance company and are your responsibility. INITIAL \_\_\_\_\_

**Court Testimony Agreement:** Erika Meek, M.Ed., LPC, NCC is not Forensic Psychologist and conducting witness/testimonial services is not the therapist's area of interest or expertise. If you have a suspicion that your case will be going to court or your need therapist testimony, please let Erika Meek, M.Ed., LPC, NCC know so I can provide you with an appropriate referral source that can meet your needs. **If you require services for court, I recommend that you hire another mental health professional for this purpose.** INITIAL \_\_\_\_\_

Erika Meek, M.Ed., LPC, NCC does not testify in court and that if I am called to testify you, the parent/guardian are aware that harm will be done to the therapeutic alliance between myself and the client and that counseling services may be terminated and referrals to mental health professionals will be provided. Should you subpoena Erika Meek, M.Ed., LPC, NCC with or without approval or involve me in court related processes, you agree to pay a nonrefundable retainer fee of **\$2,400.00** that is due at the time a subpoena is served. The charge for court-related services of any kind is **\$300.00** per hour rounded to the nearest 15 minute interval including drive and wait time. Fees incurred for these services will not be filed with your insurance company. If a subpoena is issued to me it will be turned over to our attorney and I will consult with that attorney as necessary. You agree to waive Erika Meek's involvement in any legal matters they deem not appropriate for their participation.

INITIAL \_\_\_\_\_

I UNDERSTAND THAT CERTAIN INFORMATION MAY BE REQUIRED BY THIRD PARTY SOURCES FOR THE PURPOSE OF TREATMENT, PAYMENT (INCLUDING COLLECTIONS OF PAST DUE ACCOUNTS) AND HEALTH CARE OPERATIONS. I HEARBY CONSENT FOR ERIKA MEEK, M.ED., LPC, NCC TO RELEASE MY HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. I HEARBY ASSIGN TO THE PRACTICE ALL BENEFITS/PAYMENTS FOR SERVICES RENDERED TO MY DEPENDENTS AND/OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY MY INSURANCE. MY SIGNATURE BELOW ALSO ACKNOWLEDGES THAT I HAVE READ AND AGREE TO THE CLIENT FINANCIAL POLICY AND THAT I HAVE BEEN PROVIDED ERIKA MEEK'S NOTICE OF PRIVACY PRACTICES. INITIAL \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Party Financially Responsible/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature

\_\_\_\_\_  
Date

**Erika Meek, M.Ed., LPC, NCC**  
**Therapeutic Connections Counseling Services, PLLC**

3550 Parkwood BLVD Suite A-201, Frisco, Texas 75034  
Phone: (214)797-7961

**HIPPA NOTICE OF PRIVACY PRACTICES**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your therapist, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: You protected health information will be used, as needed, to obtain payment to your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of you therapist's practice. These activities include, but are not limited to, quality assessment activities, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call your by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food or drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

**Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact **Erika Meek, M.Ed., LPC, NCC** at 3550 Parkwood BLVD Suite A-201, Frisco, Texas 75034 Phone: (214)797-7961. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services at 200 Independence Ave, S.W. Washington, D.C. 20201. Toll Free: (877)-696-6775. I will not retaliate against you if you file a complaint with the Director or with me.

**Acknowledgement of Receipt of HIPPA Notice of Privacy Practices**

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

\_\_\_\_\_  
Client signature (Parent/guardian if client is a minor)

\_\_\_\_\_  
Date

**Consent for Use and Disclosure of Health Information:**

I hereby permit and release Erika Meek, M.Ed., LPC, NCC- Therapeutic Connections Counseling Services, PLLC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be related to HMOs, PPOs, managed care organizations, IPAs, or other government or third party payers, or any organization contracting with any of the above entities to perform such functions.

\_\_\_\_\_  
Client signature (Parent/guardian if client is a minor)

\_\_\_\_\_  
Date

You have the right the request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional.

**Therapeutic Connections Counseling Services, PLLC  
Erika Meek, M.Ed., LPC, NCC**

**ACKNOWLEDGEMENT OF RECEIPT**

**NOTICE OF PRIVACY PRACTICES  
INFORMED CONSENT  
CONSENT TO TREATMENT**

By my signature below I, \_\_\_\_\_ acknowledge that I read, received copies and understand the **Notice of Privacy Practices and Practice Policies** for **Therapeutic Connections Counseling Services, PLLC**

I do seek and consent for my child to take part in the treatment by the therapist named above. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop counseling with this therapist at any time. The only thing I will be responsible for services I have already received. I understand that I may lose other services or may have to deal with other problems, if I stop treatment. (For example, if my treatment has been court ordered. I will have to answer to the court).

***I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge.***

I know I must contact the therapist to cancel at least 24-48 hours before the time of my appointments. If I do not cancel and do not show up, I will be charged for that missed appointment.

I am aware that an agent with my insurance company or other third party payer may be given information about the type(s), cost(s), date(s), and providers of any services of treatments I receive. I understand that if payment for the services I receive here are not made, the therapist may stop my treatment and seek to collect the fees.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date