COUNSELING CENTER OF NORTH TEXAS

303 S. Highway 78 Suite 100 Wylie, TX 75098
720 E. Park Blvd. Suite 204 Plano, TX 75094
Phone: 469-342-3468 Fax: 469-342-3466

CHILD/ADOLESCENT INFORMATION

Name:					
Nickname:					
DOB:		Age:		Gender:	
Cell Phone (optional):					
Address:					

PARENT/GUARDIAN INFORMATION

Primary Contact Information			
Name:			
Relationship to Child:			
DOB:			
Cell Phone:		Alternate Phone:	
Email Address:			
Address (if different):			
Employer:			

May we leave a message? ☐ Yes ☐ No Text? ☐ Yes ☐ No Email? ☐ Yes ☐ No

May we include you on our email list for mental health information and CCNT news/events? ☐ Yes ☐ No

Other Parent/Guardian Information			
Name:			
Relationship to Child:			
DOB:			
Cell Phone:		Alternate Phone:	
Email Address:			
Address (if different):			
Employer:			

Will someone other than a parent be bringing the child to appointments? ☐ Yes ☐ No If yes, provide:

_____

Name Phone Number Relationship

NOTE: The person bringing the child is expected to remain on site.

Person Responsible for Payment (if different from person completing form):

_____

Name Phone Number Relationship

_____

Address (if different from above)

PRIMARY INSURANCE

Insurance Company: _____ Insurance Phone: _____

Policy #/ID #: _____ Group #: _____ Coverage Start Date: _____

Deductible: $_____ Amount Met: $_____ Co-pay/Co-Insurance: $_____/_____%

Pre-Authorization/EAP #: _____ # of approved sessions: ____

Date Span of Approval: _____ to _____

PRIMARY INSURANCE SUBSCRIBER INFORMATION

Insured's Name: _____

Complete the following if this information was not provided above.

Relationship to Insured: _____ Insured's DOB: _____

Insured's Address (if different):_____

Insured's Phone Number: _____ Employer: _____

Is your child covered by a secondary insurance plan? ☐ Yes ☐ No If yes, please fill out an additional form.

I hereby give the office Counseling Center of North Texas and their staff permission to file any claims and exchange any PHI (Protected Health Information) necessary to receive payment for services performed. I understand that balances unpaid after 60 days will be my responsibility. If coverage is under another individual's policy, I understand that this person may be notified of services performed.

_____

Signature Date

Referred by: _____

May we thank them? ☐ Yes ☐ No

Who is/are the child's primary guardian(s)?

☐ Biological Parent(s) ☐ Adoptive Parent(s) ☐ Foster Parent(s) ☐ Grandparent(s)/Relative(s)

Status of Child's Biological Parents

If you are not the child's biological parents, please complete this section regarding their biological parents. Additional questions related to other guardians will be addressed later.

What is the relationship of the child's biological parents? (Check all that apply.):

☐ Single Mother ☐ Single Father ☐ Unmarried, Together ☐ Unmarried, Apart

☐ Married, Together ☐ Married, Separated ☐ Divorced ☐ Mother & Stepparent

☐ Father & Stepparent ☐ Mother Deceased ☐ Father Deceased ☐ Mother Unknown

☐ Father Unknown ☐ Other: _____

If divorced or separated, how old was the child at the time of divorce/separation? _____

If deceased, how old was the child at that time? _____

Current Household/Primary Residence

Name:	Age (if minor):	Relationship:

What is the relationship status of the parent(s)/guardian(s) in child's primary residence (if different)?

☐ Single ☐ Long Term Relationship ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Secondary Residence (if applicable)

Address (if not listed above): _____

Name:	Age (if minor):	Relationship:

What is the relationship status of the parent(s)/guardian(s) in child's secondary residence?
☐ Single ☐ Long Term Relationship ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Does either parent/guardian's job require him/her to be away from home long hours or extended periods outside normal situations? ☐ Yes ☐ No If yes, please explain: _____

_____

Is there an official custody agreement (if applicable)? ☐ Yes ☐ No If yes, what are the arrangements for visitation? _____

_____

Are there any PENDING visitation or custody proceedings involving your child? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Has Child Protective Services been involved with your child either now or in the past? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Non-Biological Parents

If you are not the child's biological parents, please complete the following block:

How old was the child at the time of separation from the biological parents?

_____

What conditions led to the child's separation?

_____

_____

Describe the impact of the child's separation.

_____

_____

Describe the relationship (if any) the child has with the biological parents.

_____

_____

Does your child have contact/visitation with the biological parents? If so, how frequently?

_____

_____

Other Significant Figures Not Living in the Home

Name:	Age (if minor):	Relationship:

Identify any concerns about any significant adult figures in your child's life: _____

_____

_____

Reasons for Seeking Counseling

In 1-2 sentences, tell us the reasons you are seeking counseling for your child. _____

_____

_____

When would you estimate the majority of your child's concerning behaviors/symptoms began? _____

Under what conditions are the problems usually improved? _____

_____

Medical/Mental Health History

Please list any concerns, conditions, developmental delays, illnesses, treatments, or surgeries that might be relevant to the reasons for seeking counseling: _____

_____

_____

_____

Has your child ever been tested for any psychological or developmental concerns and/or received a diagnosis related to mental health (i.e. ADHD, Autism, Depression, Anxiety, etc.)? ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

Does your child see a psychiatrist? ☐ Yes ☐ No
If yes, who?_____

Please list all current medications your child is taking and the reasons for taking them:

*For Frequency, please write down one of the following: Not applicable, Overuse, As Prescribed, Forgetful, Inconsistent, Resistant, Dissatisfied, or Discontinued

Name of Medication	Dose	Reason	Frequency used*	Any side effects?

List any counseling the child has received (including school counselor):

*For Reaction to Experience, please write down one of the following: Poor, Fair, Good, or Excellent

Name of Counselor	Age when Attended	Reason for Counseling	Reaction to Experience*

List any psychiatric hospitalization/substance abuse treatment child has had:

*For Overall Experience, please write down one of the following: Poor, Fair, Good, or Excellent

Name of Hospital	Age of Hospitalization	Length of Stay	Reason for Hospitalization	Reaction to Experience*

Family History

Has anyone in the child's family experienced difficulties with any of the following? (Please include immediate and extended family members.)

Symptom/Diagnosis	Family Member	Level of Child's Relationship
Abuse/Neglect		☐ Close ☐ Average ☐ Distant ☐ None
ADHD		☐ Close ☐ Average ☐ Distant ☐ None
Alcohol/Substance Abuse		☐ Close ☐ Average ☐ Distant ☐ None
Anxiety Disorder		☐ Close ☐ Average ☐ Distant ☐ None
Autism		☐ Close ☐ Average ☐ Distant ☐ None
Bipolar Disorder		☐ Close ☐ Average ☐ Distant ☐ None
Conduct Disorder		☐ Close ☐ Average ☐ Distant ☐ None
Depression Disorder		☐ Close ☐ Average ☐ Distant ☐ None
Eating Disorder		☐ Close ☐ Average ☐ Distant ☐ None
Family Violence		☐ Close ☐ Average ☐ Distant ☐ None
Legal Issues		☐ Close ☐ Average ☐ Distant ☐ None
Personality Disorder		☐ Close ☐ Average ☐ Distant ☐ None
Schizophrenia		☐ Close ☐ Average ☐ Distant ☐ None
Suicide		☐ Close ☐ Average ☐ Distant ☐ None

Home/Family/Events Impacting the Child – Check all that apply & star most significant					
	Current	**Past**		**Current**	**Past**
Physical Abuse			Sexual Abuse		
Neglect			Verbal/Emotional Abuse		
Parental Job Loss			Death of a Relative		
Death of a Parent			Death of a Pet		
Conflict/Separation between Parental Figures			Chronic/Terminal Illness of Loved One		
Arrest/Incarceration of Significant Adult Figure			Separation/Loss of Alternate Significant Adult Figure		
Housing Problems			Violence at Home		
Additions to Family			Multiple Family Moves		
Parents Using Alcohol/Drugs			Other Family Issue		

Child's Disposition

How would you generally describe your child's overall mood?

☐ Positive (happy, laughing, upbeat, hopeful) ☐ Negative (depressed, cranky, angry, hostile)
☐ Mixed, but more positive than negative ☐ Mixed, but more negative than positive

How would you describe your child's approach to new situations?

☐ Positive, jumps right in ☐ Withdrawn, tends not to participate ☐ Slow to warm up, cautious

Areas of Concern for Your Child – Check all that apply & star most significant					
	Current	**Past**		**Current**	**Past**
Hopelessness			Sadness/Tearfulness		
Loss of Enjoyment in Usual Activities			Worthlessness/Low Self-Esteem		
Tiredness/Fatigue			Seasonal Mood Change		
Excessive Anger			Excessive Guilt		
Loss of Awareness, Identity, or Perception			Threatened or Attempted Suicide		
Delusions or Hallucinations			Suspicion/Paranoia		
Obsessions/Compulsions			Confusion/Memory Lapse		
Repeats Unnecessary Acts Over and Over/Unusual Rituals			Difficulty Accepting Responsibility		
Phobias/Fearful			Flashbacks		
Panic Attacks			Lying		
Racing Thoughts			Separation Anxiety		
Frequent Sickness			Chronic Illness		
Thoughts or Expressions of Death or Suicide			Excessive Excitement, Euphoria, or Overactivity		
Self-Injurious Behavior			Tics/Movements/Twitching		
Excessive Worry/Anxiety			Intrusive/Negative Thoughts		
Talks Too Much or Out of Turn			Decreased Energy		
Lack of Motivation			Tantrums		
Inflated Self-Esteem			Irritability		
Inappropriate Sexual Behavior			Severe Changes in Mood		

Adverse Behaviors/Symptoms Your Child Exhibits

Functioning – Check all that apply & star the most significant					
	Current	**Past**		**Current**	**Past**
Toileting Problems			Perfectionism		
Following Directions			Disruptive Behaviors		
Laziness			Messiness		
Does Not Finish Tasks			Cannot Handle Daily Tasks		
Disorganized			Easily Frustrated		
Sitting Still			Easily Distracted		
Procrastination			Daydreams/Fantasies		
Impulsivity			Hyperactivity		
Difficulty with Eye Contact			Sensory Issues		
Difficulty Communicating			Makes Careless Mistakes		
Difficulty Controlling Emotions			Other:		

Destructive/High Risk/Unsafe Behaviors – Check all that apply & star the most significant					
	Current	**Past**		**Current**	**Past**
Property Destruction			Fire Setting		
Stealing/Shoplifting			Cruelty to Animals		
Other Criminal Activity			Arrest/Legal Issues		
Gang Activity			Other:		
Sleep Issues – Check all that apply & star the most significant					
	Current	**Past**		**Current**	**Past**
Bedtime Fears/Won't Sleep			Poor Quality of Sleep		
Sleeps Too Much			Sleeps Too Little		
Unable to Go Back to Sleep			Wakes Up Very Early		
Nightmares/Terrors			Sleep Talking		
Sleepwalking			Bedwetting		
Eating Problems/Diet – Check all that apply & star the most significant					
	Current	**Past**		**Current**	**Past**
Eating More			Eating Less		
Restricting Food			Decreased Appetite		
Overeating/Bingeing			Purging		
Body Image Problems			Overweight		
Significant Weight Change			Picky Eater		
Addictions – Check all that apply & star the most significant					
	Current	**Past**		**Current**	**Past**
Computer/Online Addiction			Gambling		
Alcohol Use/Abuse			Drug Use/Abuse		
Tobacco Use/Abuse			Sexual Behaviors		
Problems with Pornography			Other:		

Parenting

Forms of Discipline Used in the Home (Check all that apply.):
☐ Time Out ☐ Loss of Privileges ☐ Grounding ☐ Rewards/Incentives ☐ Extra Chores
☐ Physical/Corporal Punishment ☐ None ☐ Other: _____

Who is responsible for this child in the following areas (mother, father, guardian, shared, grandparent, etc.)?

School: _____

Health: _____

Problem Behavior: _____

Extracurricular: _____

Does your child do chores? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Social Support

Please identify your child's social support network (check all that apply)**:**
☐ Immediate Family ☐ Extended Family ☐ Religious Settings ☐ Extracurricular Activities
☐ School ☐ Work ☐ Neighbors ☐ Online ☐ Other: _____

Your child prefers to be around people who are: ☐ Younger ☐ Older ☐ Same Age ☐ No Preference

Your child acts: ☐ Younger ☐ Older ☐ Same Age

Relationships – Check all that apply & star the most significant					
	Current	**Past**		**Current**	**Past**
Clings to Adults			Social Withdrawal/Loner		
Shyness			Social Discomfort		
Overly Dependent			Demanding and Bossy		
Has Few Friends			Teases/Bullies Others		
Disrespectfulness			Problems with Authority		
Easily Embarrassed			Manipulative Behavior		
Fights with Others (Physically)			Conflict with Adults		
Oversensitive			Conflict with Siblings		
Controlling			Hero Mentality		
Victim Mentality			Short-Tempered		
Defiant/Disobedient			Doesn't Like to Be Touched		
Social Influences/Events Impacting Child – Check all that apply & star most significant					
	Current	**Past**		**Current**	**Past**
Teasing/Bullying			Breakup from Close Friend		
Gang Related Influence			Death of a Friend		
Interacts with 'Problem Children'			Discrimination		
Religious/Spiritual Concerns			Substance Abuse Influence		
New Friend Group			Other:		

Please answer the following issues if your child is 12 and above:

Teen Section – Check all that apply & star most significant					
	Current	**Past**		**Current**	**Past**
Gender Identity			LGBTQ+		
Rape			Sexually Active		
Promiscuity			Miscarriage		
Abortion			Teen Parent		
Drag Racing/Reckless Driving			Shoplifting		
Sneaking Out/Violating Curfew			Dating		
Break-up			Sexual Harassment		
Ran Away			Other:		

Educational Information

School: _____ ISD: _____ Grade: _____

Has your child ever changed schools (other than normal transitions)? ☐ Yes ☐ No If yes, please explain:

_____

Does your child attend an afterschool program? ☐ Yes ☐ No If so, where? _____

If not, who supervises the child when they are not in school? _____

School Grades/Behavior/Attitude – Check most applicable					
	Poor	**Fair**	**Good**	**Excellent**	**N/A**
This year's school grades:					
Past school grades:					
This year's school behavior:					
Past school behavior:					
This year's attitude toward school:					
Past attitude toward school:					
Parents' satisfaction with grades:					

School Stressors/Events Impacting Child – Check all that apply & star most significant					
	Current	**Past**		**Current**	**Past**
Detention/Suspension			Expelled		
Learning Problems/Special Ed			Repeated Grade		
Excessive Worry about Academics			Attendance Problems		
Schoolwork/Homework Difficulty			IEP and/or 504 Plan		
Trouble with Teachers			Skipped Grade		
Gifted and Talented			Bored		

Religious/Spiritual Considerations for Family

Religious Upbringing: ☐ Yes ☐ No Present Affiliation: _____

Do you attend services? ☐ Never ☐ Rarely ☐ Sometimes ☐ Regularly ☐ Often

How important are religious/spiritual matters to your child/adolescent? ☐ Not At All ☐ Some ☐ Very Much

How important are religious/spiritual matters to you? ☐ Not At All ☐ Some ☐ Very Much

Extracurricular Activities/Hobbies

What extracurricular activities and hobbies is your child interested/participate in? _____

_____

What are your child's strengths/talents/achievements? _____

_____

Therapy Goals

☐ Reduce Anxiety ☐ Improve Mood ☐ Process Feelings
☐ Increase Self-Esteem ☐ Improve Behavior ☐ Eliminate Unhealthy Coping Skills
☐ Adjust to Recent Changes ☐ Improve Relationships ☐ Develop Healthy Coping Skills
☐ Other: _____

Welcome! Thank you for choosing Counseling Center of North Texas (CCNT). The following information will acquaint you with information relevant to treatment, confidentiality, and policies. Although this document is long and at times complex, it is very important that you understand your rights and responsibilities as well as your therapist's rights and responsibilities. Please inform your therapist of any questions you have regarding any of these polices.

Available Services

The therapists at CCNT offer a wide array of counseling services including individual, couples, family, and group sessions. While some clients benefit from just one of these types of sessions, some find using more than one useful. Please speak with your therapist about your specific needs and goals for counseling so that an effective treatment plan can be utilized.

Risks and Benefits

At any time, you may initiate a discussion of possible positive or negative effects of counseling. You should be aware that while counseling may offer significant benefits, it may also pose risks and specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes could be temporarily distressing. You may learn things about yourself that you do not like as well as unearth strengths that you did not know you possess. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work depends on the quality of effort you are prepared to give this endeavor. Together we will work to achieve the best possible results for you.

Appointments

Appointments are ordinarily 45 minutes in duration once per week although sessions may be more or less frequent as needed depending on your specific needs and treatment goals. Appearing for your sessions on time and consistently is an important part of the therapeutic process. While some clients need only a few sessions to achieve their goals, others may require several months or even several years of counseling. Session times are reserved solely for you each week at a mutually agreed upon time. The standard time for therapists to wait for clients to arrive is 15 minutes. If you are more than 15 minutes late, please contact your therapist as the session will be considered canceled.

Session Fees

My fee is $____ for an initial session, $____ for a 45 minute individual session and $____for a family session. The actual cost to you may vary due to insurance coverage or if you are using an Employee Assistance Program (EAP) as long as the sessions are covered. You are responsible for all deductibles, co-insurance amounts, and/or co-payments. If a minor is the client, the adult bringing the child to the appointment and/or the person responsible for payment agrees to pay for session costs at the time of service unless arrangements have been made prior to the session independent of what a divorce decree may state. Reimbursement must be made between divorced parents. We are unable to intervene. You may request a statement of charges at any time. Our office is unable to carry balances longer than 60 days, regardless of insurance payment. After 60 days, we will inform you of the account balance by mail and if no action is taken to clear the account, our office will be required to turn this balance over to a credit recovery service, which may report medical collections to the standard credit reporting agencies adversely affecting a clients' credit score, or to small claims court dependent upon the amount due. Any fees associated with balances sent to small claims court will be added to the balance due as will any fees associated with balances sent to a collection agency, which may be based on a percentage at a maximum of 35% of the debt. Sessions will be discontinued if an outstanding balance develops without the establishment of payment arrangements. If a credit card is used for any balance due and these charges are later disputed with the credit card company, Counseling Center of North Texas reserves the right to provide confidential information needed to justify charges with the credit card company.

Insurance

CCNT will be glad to work with you and your insurance company when your therapist is an in-network provider. In these situations, your therapist will file claims on your behalf; however, it is ultimately your responsibility to see that authorizations or referrals are obtained, that mental health is covered by your policy under the insurance company you specify, and that the therapist of your choosing is in network with your insurance company. Occasionally insurance companies will farm out mental health services to alternate insurance companies; if this occurs, you are responsible for charges incurred. Due to the varying credentialing requirements of insurance companies, therapists' insurance involvement varies. If an unpaid claim exists for more than 60 days, your balance becomes your responsibility in full and CCNT will provide a receipt for you to seek reimbursement from the insurance company. If there is a change in insurance, it is your responsibility to notify your therapist and provide a copy of the new insurance

card. If your therapist is not in network with your insurance company, a receipt for services may be provided so that you may submit them to the insurance company and potentially be reimbursed for the session costs.

Cancellations and Missed Appointments

In the event that you must cancel an appointment, please notify your therapist at least 24 hours in advance of your scheduled appointment. If you fail to give at least 24 hours notice, you will be charged the full fee of the session as the session time is reserved for you and another client cannot be scheduled in your place. If a minor child or client being covered by a guardian's insurance policy (thus making them the guarantor) incurs fees, the guardian/guarantor will be held legally responsible for any fees incurred including cancellation fees. Please make sure you keep records of your appointment schedule – last minute contacts to verify date and time that result in your not keeping an appointment will result in a cancellation fee. Cancellations within the 24 hours prior to a scheduled appointment or where you no show the appointment will be charged to the credit card on file. NOTE: If you typically utilize insurance, insurance does not reimburse for cancelled appointments; therefore, the amount owed will be the full session fee as opposed to your normal co-insurance or co-payment amount.

Returned Check Fee

There will be a $25.00 fee for any checks returned from your bank. Committing check fraud is a felony and if a returned check is not cleared within a month, this matter will be turned over to our check recovery service and may be turned over to the Collin County District Attorney's Office for prosecution.

Court Related Fees

If you become involved in litigation that requires the participation of your therapist including, but not limited to, divorce, custody disputes, or cases involving CPS or criminal activity, due to the complexity and difficulty of legal involvement, there is a fee of $160 per hour for preparation for, travel to and from, and attendance at any legal proceedings as well as preparation of records and treatment summaries associated with a subpoena. A $1600 retainer will be required immediately upon therapist receiving a subpoena and/or court appearances are requested. Due to the immediate response needed, $640 of this retainer is non-refundable once a subpoena is issued, regardless of whether your therapist is later released from appearing. Because the length of a court hearing cannot be pre-determined, all other appointments on said date must be cancelled; therefore, there is a 4 hour minimum for the date of the court hearing regardless of whether testimony occurs. Two weeks advance notice releasing your therapist from the court hearing must be provided to avoid this 4 hour minimum. Should your therapist be required to appear yet does not testify or is released early, the fees remains as their schedule was cleared to accommodate. There is a $10 per hour discount for court related fees paid using cash, check, or money order. Any unutilized retainer funds will be put towards any account balances. Refunds will be issued no sooner than one full billing cycle after all court proceedings have ceased. CCNT will notify you if retainer funds fall below $800. If this occurs, retainers must be replenished to $1200 immediately and no less than one business day prior to any court hearings. If a client is involved in a lawsuit that creates a situation where your therapist is court ordered to be involved, the initiating party is responsible for the fees listed above. In cases involving the District Attorney's office, the fees are the client's responsibility.

Other Possible Fees

It is our center's practice to charge for other professional services you may require such as report writing, treatment summaries, consulting with other professionals on your behalf, and telephone conversations lasting longer than 5 minutes. LPC's, LCSW's, and LMFT's charge $140 per hour on a prorated basis (per quarter hour). LPC-Associates, LMSW's, and LMFT-Associates charge $100 per hour on a prorated basis (per quarter hour). Practicum Students charge $80 per hour on a prorated basis (per quarter hour).

Confidentiality

The law protects the privacy of all communication between a client and a therapist and information from session can only be released to others with written permission or in certain specific situations described below. Even with written consent, your therapist will always act so as to protect your privacy. You may permit your therapist to share information with whomever you choose and you can revoke that permission at any time.

The following circumstances are legal exceptions to your rights to confidentiality:

- If information has been provided that indicates a child, elderly, or disabled person is being abused or neglected, your therapist must inform either the Texas Department of Family and Protective Services or the local police within 48 hours.
- If there is good reason to believe that you will harm another person, your therapist must warn the authorities of your intentions.
- If there is reason to believe that you are in imminent danger of harming yourself, your therapist may legally break confidentiality and call the police.

- If your therapist receives information that a previous therapist has been sexually exploitative, your therapist will make a report to the appropriate licensing board.

Furthermore, information may be released if your therapist is ordered by the court or subpoena to provide information regarding your treatment and/or diagnosis or if you have given permission for exchange of information for insurance purposes. Should such a situation occur, every effort will be made to contact you first prior to releasing information.

To ensure you receive the best care possible, mental health professionals regularly seek consultation with colleagues for coordination of care, to ensure the highest quality of therapy for the clients, and to analyze personal biases as a means of maintaining the highest standards for your care. Cases may be discussed in detail during consultations with CCNT staff members and practicum students as well as during supervision with Vanessa Gill and/or Amanda Cortez. In addition, the employees of Counseling Center of North Texas have access to all offices and filing cabinets containing confidential information; therefore, confidentiality exists within the practice as a whole. The staff of CCNT are also legally bound to keep the information confidential. All LMFT-Associates, LMSW's, LPC-Associates, and practicum students are involved in regular supervision, in which cases may be discussed in detail. Please see the Supervisory Disclosure form for a list of supervisors. The supervisors of therapists are subject to change with staff changes. Those staff members requiring supervision will inform all new clients of their supervisor's name and number and all current clients of any changes in supervisor. Therapists who are not under supervision or whose supervisor has not changed will not notify clients of any changes in the list of supervisors.

Additional exceptions

- Any individual attending group, joint marriage sessions and/or any family sessions has access completely to the records of that session. It is our policy to attempt to release records to all parties who were present when one party requests records for a joint marriage and/or family session.
- Marriage Counseling: If you or your partner decide to have individual sessions in addition to family or couples therapy, what you say in those individual sessions will be considered to be a part of the couple or family therapy and can be discussed in joint sessions. Although not a legal exception to your confidentiality, you should be aware of this policy before proceeding with sessions involving others. Your therapist will remind you of this policy in your initial session.
- Parents of Adolescents: If the client is a child or adolescent and is engaging in reckless behavior or persistent substance use, a need to discuss these activities with their parent will be discussed. The minor will then be given the opportunity to inform their parent/guardian during the counseling session of behaviors that are deemed by the counselor a harm to self. Please understand that we will not betray confidences of parental defiance or rebellion that are not life threatening. We will make every effort to encourage the minor to be forthright with their guardians as transparency is a recognized dynamic of a healthy relationship. If a parent feels betrayed by our keeping of confidentiality, we encourage the family to schedule a family session to discuss this matter.
- Parent Consultation: Also, in counseling involving a minor child as the identified patient, the rights of confidentiality extend to them only. If you share information during a parent consultation that would impact their treatment or if the child is present, realize that either parent has access to the child's records and anything said by the other parent would not be considered confidential during a family session or parent consultation since they are not a counseling patient.
- Legal Issues: If at any time you involve any staff member or CCNT as a company in legal proceedings including but not limited to requesting files for an attorney, having a subpoena issued by an attorney or court, requesting a staff member give a deposition, or verbally or in writing threatening to name a staff member or the organization in a lawsuit, we will disclose case information to our attorney in order to follow best legal and ethical practices when addressing these issues.

Release of Records

You are able to receive a copy of your records should you choose. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, it is recommended that you review them in your counselor's presence so that you can discuss the contents together. Most often a summary is supplied to help avoid any difficulty in understanding the true meaning. Vanessa Gill is the custodian of all files for CCNT and is responsible for the release of these files when requested in their entirety. Clients will be charged $160 an hour for any preparation time required to comply with an information request including a minimum fee of $60 for copies of records less than 50 pages and a minimum fee of $160 for copies of records more than 50 pages. Two weeks notice is required to allow for these records to be prepared. Records will not be released if there is a balance on the account. If records are requested for presumed legal purposes and/or at the request of an attorney, please see the section titled "Court Related Fees." There is a discount for fees paid using cash, check, or money order. If for any reason, your therapist becomes unavailable due to illness, injury, or death, please contact Vanessa Gill at 469-342-3468, or if she is unavailable, Amanda Cortez at 469-342-3468. Amanda Cortez will become custodian of all files that have not been destroyed should Ms. Gill become incapacitated. Files are shredded seven years after the date of your final session or in compliance with State Board and HIPAA guidelines.

Electronic Communication

Counseling Center of North Texas is committed to maintaining our client's privacy. Our staff utilizes business practices, which may constitute a potential risk to your confidentiality, in spite of the security measures that we have in place to protect your privacy. These practices include, but are not limited to, use of electronic calendars, use of paper calendars, use of cell phones for communication with you and other professionals, use of laptop computers, use of unencrypted email, use of computerized billing, and use of an internet based phone system. By consenting to treatment, you acknowledge the possible risk and consent to treatment with our practice.

Contacting Your Therapist

The main telephone number is 469-342-3468. Should you need to speak with your therapist in between sessions, you may reach him/her at this number or via their own personal cell phone. Your therapist does not answer calls during session, so please leave a detailed message. Every effort will be made to return your call by the end of the next business day with the exception of weekends and holidays and otherwise noted on your counselor's outgoing message. Due to confidentiality restraints, your therapist is often unable to answer his/her cell phone when not at the office; therefore, text message or email communication may be responded to quicker than phone calls. Occasionally, we realize urgent matters arise and brief messages sent by text or email regarding a scheduling issue may occur. If your counselor does not respond, you will need to follow up with a phone call and leave a message. It is your responsibility to confirm their receipt of any information sent by text or email. If you have a crisis during business hours, you may contact your therapist about the possibility of scheduling an emergency session. If your therapist is unavailable or you experience a crisis outside of business hours, call 911 or go to your nearest emergency room. Should you wish to contact your therapist by phone between sessions, a fee does apply. Please speak with your therapist about the cost of these phone calls. Phone calls cannot be billed under insurance and will be the responsibility of the client. All fees for phone calls will be charged to the credit card on file unless other arrangements are made for payment at the time of the call.

Minors

If you are seeking therapy on behalf of a minor child, you must be the legal guardian and have the power to give medical/psychological consent. If you and the child's other parent are divorced, a copy of the divorce decree stating the above is required for any follow up visits. Please be advised that asking a therapist to reveal their records or appear in court is rarely therapeutic for children participating in therapy because it destroys their safe place and their trust in their therapist.

Termination

As a client, you are in complete control of how many sessions of counseling you wish to have. Should you have any questions or concerns about the course of your treatment, please discuss these with your therapist. You can request that your therapist refer you to someone else if you decided they are not the right therapist for you. After two "no shows," your therapist has the right to terminate sessions and refer you out. If you cancel three scheduled appointments, with or without notice, within a 2 month period, your therapist has the right to terminate sessions and refer you out. All therapeutic relationships will be terminated after the final session or 30 days after the last session if no contact has been made with your therapist and/or no sessions have occurred or been scheduled. You can reinitiate therapy after the therapeutic relationship has been terminated should you need to do so by contacting your therapist to schedule an appointment.

Written Acknowledgement and Consent to Counseling

I affirm the accuracy of the personal information provided herein. I have read and accept this agreement and herewith consent to counseling/psychotherapy with Counseling Center of North Texas. I acknowledge receipt of Notice of Policies and Practices to Protect the Privacy of Your Health Information and CCNT Informed Consent. I acknowledge that if I am the signing on behalf of a minor child, I am their legal guardian and have the power to give medical/psychological consent. I have been informed a copy of my divorce decree proving the above is required for any follow up visits.

Client/Legal Representative Signature	Date
Client/Legal Representative Signature	Date
Therapist Signature	Date

COUNSELING CENTER OF NORTH TEXAS

303 S. Highway 78 Suite 100 Wylie, TX 75098
720 E. Park Blvd. Suite 204 Plano, TX 75094
Phone: 469-342-3468 Fax: 469-342-3466

Credit Card Information and Authorization for Payment of Services

I, _____, authorize Counseling Center of North Texas to charge the below-referenced credit card in the following situations:

- When I have not cancelled my scheduled appointment within 24 business hours or fail to show for my scheduled appointment time, including those situations when I arrive more than 15 minutes after the session start time.
- When I contact my therapist via phone for all conversations lasting longer than 11 minutes.
- When a balance is due on my account for longer than 60 days including those balances owed due to my insurance company not covering services.

Credit Card Information

Card Type:

Visa Mastercard Discover Other: _____

Card Holder Name Listed on Credit Card: _____

Credit Card Number: _____

Credit Card Expiration Date: _____

Credit Card Security Code: _____

Credit Card Holder's Address: _____

Authorized Card Holder Signature: _____

Date: _____

Consent for Recurring Charges

In addition to the situations listed above, I authorize this credit card to be used as payment for ongoing charges incurred at the Counseling Center of North Texas.

Authorized Card Holder Signature: _____

Date: _____

Client Name: _____ Date of Birth: _____

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Supervisory Disclosure

All LMFT-Associates, LMSW's, LPC-Associates, and practicum students employed by Counseling Center of North Texas are under the supervision of one of the following:

Marshia Allen, LPC-S
6110 W. Parker Rd
Plano, TX 75093
682-236-6023

Tiffany Ashenfelter, LPC-S
12740 Hillcrest Rd, STE 270
Dallas, TX 75230
214-563-8980

Amanda Cortez, LCSW
303 S. Highway 78, STE 100
Wylie, TX 75098
469-342-3468

Robert Fine, LPC-S
1700 Alma Dr, STE 305
Plano, TX 75075
214-499-8755

Vanessa Gill, LCSW
303 S. Highway 78, STE 100
Wylie, TX 75098
469-342-3468

Lisa Grubb, LPC-S
2060 Kamla Rd
Lewisville, TX 75067
972-742-0218

Daniel Gowan, LPC-S
17210 Campbell Rd, STE 175
Dallas, TX 75252
972-267-2800

Summer Land, LPC-S
PO Box 2256
Frisco, TX 75034
214-912-5538

Jacqueline Mahoney, LCSW
6401 W Eldorado Pkwy, STE 207
McKinney, TX 75070
214-718-4430

Rochelle Ritzi, LPC-S, RPT-S
2007 N. Collins Blvd, Suite 301
Richardson, TX 75080
469-930-0171

Ryan Smith, LMFT-S, LPC-S
670 N. Stodghill Road
Rockwall, TX 75087
214-304-9540

These supervisors are subject to change depending on staff changes and/or a shift in therapists' needs. Those staff members requiring supervision will inform all clients of their supervisor's name and contact information and of any changes that occur. If your therapist is not under supervision or there has been no change to their supervisor, there will be no notification if the list above changes.

An individual who wishes to file a complaint against a Licensed Marriage and Family Therapist, Licensed Professional Counselor, or Licensed Social Worker may call 1-800-821-3205 or write to:

Texas Behavioral Health Executive Council
Attn: Enforcement Division
333 Guadalupe St. Tower 3, Room 900
Austin, Texas 78701

_____ _____
Client/Legal Representative Signature Date

_____ _____
Client/Legal Representative Signature Date

_____ _____

Therapist Signature Date

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Telehealth Informed Consent

This document pertains to telehealth specifically and the policies herein are in addition to the general policies of Counseling Center of North Texas. As a client receiving telehealth services through Counseling Center of North Texas, I understand the following:

"Telehealth" is the delivery of mental/behavioral health services including consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications between a provider and a client who are not in the same physical location and may or may not involve direct face to face communication. Telehealth also involves the communication of my medical/mental information, both orally and visually. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption; however, technology utilized outside of video conferencing is not encrypted and may not be HIPAA compliant. Likewise, it is your responsibility to keep all information exchanged secure and to create an environment on your end that is not subject to unexpected or unauthorized intrusion of your personal information. We recommend that you refrain from allowing others to be in the room during telehealth sessions. Your therapist may terminate the telehealth session if your identity cannot be determined and/or if persons other than you are found to be in the room.

Benefits and Limitations:

There are benefits and limitations to telehealth. It is our expectation that you will benefit from online therapy as all or part of your psychotherapy, but there is no guarantee. Telehealth offers you added convenience and increased accessibility to psychological care; however, online-based services are not the same as traditional treatment. Telehealth may not be appropriate for your needs as some overwhelming or potentially dangerous challenges are best met with traditional therapy. Furthermore, information transmitted may not be sufficient to allow for appropriate psychological decision making by your provider. The appropriateness of continuing to deliver services through the use of technologies we have agreed upon should be regularly assessed and will be modified as needed. If it is determined that traditional therapy is better suited to your needs, your therapist will discuss scheduling options or provide referrals as necessary. There is no guarantee that an opening may be immediately available. It is your responsibility to schedule and attend these sessions if necessary. Clients receiving telehealth must be located in the state of Texas to be eligible for telehealth services from Counseling Center of North Texas.

There are risks involved in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, access by unauthorized persons, and disruption of service due to technical difficulties. Should disruption of service occur, attempts will be made to reconnect up to the usual session end time. Sessions that do not occur or end early due to technical issues will incur the usual and customary fees associated with the session.

You are responsible for providing the necessary personal computer, personal telecommunications equipment and internet access for telehealth sessions, the information security of personal computer, arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for telehealth session, the security of any emails or communication on your personal computer or smartphone. You are responsible for securing such personal technology items and determining that they are in proper working order before the time the session is scheduled to begin. You may need to contact a designated third party for technical support to determine your computer's readiness for telehealth prior to beginning telehealth sessions.

Records

The laws regarding your access to medical information and copies of your medical records also apply to telehealth sessions with Counseling Center of North Texas. Please refer to initial intake policies related to records.

Confidentiality:

The laws that protect the privacy and confidentiality of psychological information also apply to telehealth. Please refer to the confidentiality section in the initial intake form as well as our Notice of Privacy Practices for more details. Telehealth sessions cannot be recorded by either party without prior written consent. Furthermore, both parties will notify the other if anyone can see or hear the interaction before the session begins. If a third party is required to join the meeting for technical support your therapist will inform you that such support is needed. The possibility exists that the technical support personnel may need to interact with you on camera for the purpose of solving technical difficulties encountered. If you do not wish to interact with technical support, it may render the option of telehealth unusable until such difficulties can be resolved.

Communication Between Sessions:

We understand that you may need to contact your therapist between telehealth sessions. CCNT's main line is 469-342-3468. In addition, your therapist may have provided a direct phone number for you to call or text. Please note that messages are returned within 24 hours or by the end of the next business day, unless alternate instructions are left on your therapist's voicemail.

Emergency:

Telehealth does not provide emergency services. During our first telehealth session, you and your provider will discuss an emergency response plan. If you are experiencing an emergency, call 911 or proceed to the nearest hospital emergency room for help. If you are having suicidal thoughts or making plans to harm yourself, you may also call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free, 24-hour support.

Payment/Cancellation Policy:

Payment for telehealth sessions is due in full before the start of each session. Credit cards are the preferred method of payment for telehealth sessions, but cash or check can be dropped off or mailed in prior to your scheduled appointment time. When applicable, telehealth sessions will be billed to the insurance company designated. Some insurance plans do not cover telehealth services even if they cover traditional therapy sessions. It is important to understand that there is the possibility that your insurance may deny coverage of telehealth sessions. In this event, you would be responsible for the charges incurred. Appointment times are reserved for you. Please contact your therapist directly regarding any changes to your appointments. Twenty-four-hour notice is required for cancellations or you will be responsible for the full session fee.

I have read and understand the information provided above regarding telehealth. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I hereby give my informed consent for the use of telehealth in my psychological care and authorize Counseling Center of North Texas to use telehealth in the course of my diagnosis and treatment. I understand that I can withdraw my consent to telehealth at any time by providing written notification to Counseling Center of North Texas without jeopardizing my access to future care, services, and benefits. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Client/Legal Representative Signature Date

_____ _____

Client/Legal Representative Signature Date

_____ _____

Therapist Signature Date

Client Name: _____ Date of Birth: _____

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA") and regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As licensed practitioners in this state, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Vanessa Gill, LCSW, Privacy Officer for CCNT at 303 S. Highway 78 Suite 100 Wylie, TX 75098

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer Vanessa Gill, LCSW at 303 S. Highway 78 Suite 100 Wylie, TX 75098 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.