corbella
individual • couples • family • play therapy

Client Information

Name _____ Referred By _____

Gender _____ Age _____ DOB _____

Address _____ City _____ State _____ Zip_____

Cell Phone _____ Home Phone _____ Other _____

E-mail address _____

Where would you like me to contact you? ☐ Cell ☐ Home ☐ Other ☐ Email ☐ None

Where would you like me to leave a message? ☐ Cell ☐ Home ☐ Other ☐ Email ☐ None

Occupation_____ Employer _____

Emergency Contact Name _____ Relationship _____

Cell Phone _____ Home Phone _____ Other _____

Financial Responsibility

Name _____ Relationship to Client _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Cell Phone _____ Home Phone _____

Employer _____ Occupation

_____

Authorization and Release: I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Toni Scalise Borowczak, M.S., LPC-S, RPT-S, NCC the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him for services rendered and/or for cancelled or missed appointments.

signature date

Mental Status Information

Are you currently thinking of harming yourself in any way? ☐ Yes ☐ No

If yes, please describe _____

Are you currently experiencing suicidal thoughts? ☐ Yes ☐ No

If yes, please describe _____

Have you ever had any thoughts in the past (of suicide or harming yourself in any way? ☐ Yes ☐ No

If yes, please describe with approximate time (days/weeks/months/years)

when thoughts occurred _____

_____

Are you having any thoughts about harming anyone else in any way? ☐ Yes ☐ No

If yes, please describe _____

Counseling History

Are you currently receiving mental health counseling services? ☐ Yes ☐ No

If yes, please describe _____

Have you ever received mental health counseling services? ☐ Yes ☐ No

If yes, please describe _____

Are you currently under probation? ☐ Yes ☐ No

If yes, please describe _____

About Your Concerns

Please describe thoughts, feelings, or behaviors currently troubling you _____

_____

_____

How long have you been experiencing these concerns?: _____

Please list anything else you would like me to know: _____

_____

About Your Daily Routine

What time do you go to bed? _____ When do you wake-up? _____ Average hours of sleep? ___

Do you have any problems getting enough sleep? ☐ Yes ☐ No Wake up frequently? ☐ Yes ☐ No

If yes, please describe _____

How much caffeine do you consume each day? ☐ None ☐ 1-3 drinks ☐ 4-6 drinks ☐ more than 6

How much alcohol do you consume each week? ☐ None ☐ 1-3 drinks ☐ 4-6 drinks ☐ more than 6

What kinds of physical exercise do you enjoy? _____

How often do you exercise? _____

Is your eating restricted in any way? ☐ Yes ☐ No

If yes, please describe _____

About Your Health

Who is your primary care physician? _____

When was your last visit? _____

Any concerns shared by the doctor? ☐ Yes ☐ No

If yes, please describe _____

Allergies? ☐ Yes ☐ No

If yes, please describe _____

List all medications or drugs you take or have taken in the last year — including prescribed and over-the-counter

_____

_____

_____

_____

Starting with birth and proceeding to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

_____

_____

_____

_____

About Your Family of Origin

Relatives	Name	Age	How Well Do you Get Along With This Person? 1=Poorly to 5=Very Well	Occupation
Father			1 2 3 4 5	
Mother			1 2 3 4 5	
Sister(s)			1 2 3 4 5	
Brother(s)			1 2 3 4 5	
Step Mother			1 2 3 4 5	
Step Father			1 2 3 4 5	
Step Sister(s)			1 2 3 4 5	
Step Brother(s)			1 2 3 4 5	

About Your Current Family

Relatives	Name	Age	How Well Do you Get Along With This Person? 1=Poorly to 5=Very Well	Occupation
Spouse/ Partner			1 2 3 4 5	
Child 1			1 2 3 4 5	
Child 2			1 2 3 4 5	
Child 3			1 2 3 4 5	
Child 4			1 2 3 4 5	
Child 5			1 2 3 4 5	
Step Child 1			1 2 3 4 5	
Step Child 2			1 2 3 4 5	
Step Child 3			1 2 3 4 5	
Step Child 4			1 2 3 4 5	
Step Child 5			1 2 3 4 5	

Is there a history of mental illness in your family? ☐ Yes ☐ No

If yes, please describe

Does any family member have a current or chronic illness? ☐ Yes ☐ No

If yes, please describe

PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT
Toni Scalise Borowczak, M.Ed.., LPC-S, RPT-S, NCC
Texas License No. 62929

QUALIFICATIONS: I am a graduate of the University of North Texas where I received a Masters in Counseling. Based on my education, further training and experience, I am qualified to work with children, adolescents, parents, groups, and adults. I have been in private practice since May, 2009. I have worked with clients of all ages and with varying presenting problems. My theoretical orientation and application is rooted in Adlerian Psychology..

INFORMED CONSENT:

- Both parents or legal guardians must initial next to each item and sign where requested (either on the same or separate copies of this document.) _____/_____

- I understand that Toni Scalise Borowczak does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1, or go to an emergency room for assistance. _____/_____

- I understand that Toni is in the office Monday through Thursday, and if an e-mail or phone call is received after 4:30 p.m. on a Thursday, my communication may not be returned until the following Monday. _____/_____

- I understand that during the time that we work together, we will meet weekly for approximately 45 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. _____/_____

- I understand our contact will be limited to counseling sessions and phone contact. If a phone consultation is necessary you may call Toni at (214) 433 - 6433 xt 700. Applicable fees for phone consultation services ***exceeding 15 minutes*** will apply. _____/_____

- I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and those specific results are not guaranteed although benefits are expected from counseling. _____/_____

- I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in my life perspectives and decisions. These changes could be temporarily distressing. _____/_____

- I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with Toni Scalise Borowczak's services as a therapist, I have a right to let her know. If I do not feel that Toni may resolve my complaint, I may file a formal complaint by contacting with the Texas Board of Examiners of Licensed Professional Counselors at 1(800) 942-5540. _____/_____

- I understand that our paths may cross in social situations but that our therapeutic relationship comes first. In order to protect my confidentiality Toni will not initiate a greeting and will only address me if I initiate contact. _____/_____

- Should Toni believe that a referral is necessary, she will provide me with said referrals. _____/_____

FOR PARENTS AND COUPLES ONLY:

- I understand that if I am seeking services that involve another person (parent, partner, ex-partner, etc) that Toni Scalise Borowczak will not "keep secrets" from the other party if receiving services together. If I divulge information to her in private, she will highly encourage full disclosure with the other party involved and facilitate the process. If full disclosure is not possible, she may terminate joint counseling and only see one member of our party or refer us to another therapist. _____/_____

- I understand that the following parental factors greatly contribute to positive outcomes in my child's therapy: _____/_____
    - consistent attendance to regularly scheduled therapy sessions
    - parental attendance to regularly scheduled parent consults
    - parental responsiveness to therapeutic suggestions
    - parental attitude towards the therapeutic process

- I understand that failure to attend parent consults or failure to respond to therapist's communication requests may result in the termination of therapy at the therapist's discretion. _____/_____

CONFIDENTIALITY:

- I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are ***typical, but not exhaustive***, examples of situations and circumstances under which information may be disclosed without prior consent:

    - You are a danger to self or someone else.
    - In situations of ***suspected*** child, spouse, or elder abuse, it is the legal duty of the mental health provider to notify medical, legal, or other authorities.
    - You disclose sexual contact with another mental health professional.
    - If you or your child is involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
    - Toni Scalise Borowczak is ordered by a court to disclose information.
    - You direct Toni Scalise Borowczak in writing to release your records.
    - Toni Scalise Borowczak is otherwise required by law to disclose information.

- I have read and understand each of the aforementioned limits to client confidentiality. ____/_____

- I understand that should an emergency occur with Toni Scalise Borowczak, Sarah Balint Bravo, owner of Park Cities Child & Family Counseling may contact me on Toni's behalf. ____/_____

- I understand that should Toni Scalise Borowczak become incapacitated or deceased, her files will become the property of Toni Borowczak. If Toni should become incapacitated or deceased, files will become the property of the designee in her will. Currently that designee is Sarah Balint Bravo with Park Cities Child & Family Counseling. ____/_____

FINANCIAL:

- I understand that the rate for 45-minute child counseling sessions or 50-minute adult therapy sessions and parent consultations are $160. Rates differ for family sessions, extended time, and phone calls. Cash, checks or credit cards are acceptable forms of payment. _____/_____

- I understand that all fees for counseling are due after each session. Appointments for additional sessions cannot be made until my balance is paid in full or other payment arrangements have been made. _____/_____

- I understand that if a check is returned, a processing fee of $25 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25 processing fee. After a returned check, the office requires credit card or cash payment of future appointments. _____/_____

- I understand that if a returned check is not cleared up in 30 days, Toni Borowczak, owner of Corbella Counseling, will file a suit with the Dallas County District Attorney's Office. _____/_____

- I understand that I am responsible for any appointments that are not canceled at least 24 hours prior to my appointment time, with the exception of an emergency. I understand that if I do not cancel my appointment 24 hours ahead of time or fail to appear for the scheduled appointment, the full session fee will be charged. _____/_____

- If a balance exists longer than 30 days and no arrangements have been made to pay the balance, the credit card on file will be charged for the remaining balance. _____/_____

COURT:

- I understand that should I subpoena Toni Scalise Borowczak as a factual case witness or involve her in court-related processes, she charges a retainer fee of $1,500, with a charge of $160 every hour she is involved in case preparation, phone calls, travel, and witness time etc. _____/_____

- I understand that if I do issue Toni Scalise Borowczak a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment. _____/_____

- I understand that my records and all of our communications become part of the clinical record. Records are the property of Corbella Counseling, PLLC. Client records are disposed of five (5) years after the client has stopped receiving services. _____/_____

TECHNOLOGY USAGE:

- I understand that personal content sent via text or email is not secure and can potentially be compromised. _____/_____

- I understand that Toni Scalise Borowczak/Toni Borowczak/Corbella Counseling will not be held liable for personal information that I choose to send via email or text should confidentiality be compromised. _____/_____

- I understand that emails and texts should only be used for scheduling or exchanging information pertaining to appointments. Toni will not respond to personal content sent via email or text unless it is requested. Should I need to speak with her in-between sessions with topics other than scheduling, I will do so by phone. _____/_____

- I understand that this is a professional relationship and therefore, invitations to Facebook, Instagram, LinkedIn, or ***any other social media site*** will not be accepted. _____/_____

STATEMENT OF UNDERSTANDING

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.

_____

Client Signature Date

HEALTH PROVIDERS STATEMENT

I have inquired to insure that the patient understood the above description of the limits on confidentiality.

_____

Health Provider's Signature Date

HIPAA 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 of 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: Your protected health information will be used, as needed, to obtain payment for 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 your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our office. In addition, we may call you 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 and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

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

_____ _____

Client signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Corbella Counseling 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 released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client signature (parent or guardian if minor patient) Date

You have the right to 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 on your signing this consent.