# Counseling by Kate, PLLC

Kate Knapp Lengyel, J.D., M.S., LPC, Mediator

Licensed Professional Counselor

**Name**_____ **Date**_____

**Address**_____ **City** _____ **Zip** _____

**Phone #'s: HM** _____ **WK**_____ **Mbl** _____ **□ message OK?**

**E-Mail Address** _____ **□ Check if OK to send email.**

**# of Children** _____ **Marital Status** _____**Age** _____ **Birthday** ____ /____ /_____

**Employment** _____ **SS#** _____

**DL #** _____ **Referred by:** _____

**Person Responsible for Payment:** _____

**Insurance carrier:** _____ **ID:**_____

**Group #:**_____ **Primary Insured Name** _____

**Primary Insured DOB** _____ **Primary Insured SS#**_____

***Emergency Notification*:**

**Name** _____**Relationship** _____ **Phone** _____

I hereby give the office of Counseling by Kate permission to begin services with me for the purpose of counseling, parenting coordination, parent coaching or collaborative law. I also give it permission to exchange any information necessary for services performed and insurance claims billing (if necessary). I also acknowledge **receipt of Notice of Policies and Practices to Protect the Privacy of Your Health Information.**

_____ _____

**Signature** **Date**

## Counseling by Kate has permission to leave messages and communicate with me even though it may contain personal health information:

**□cell □home □work □email □text**

**The information of the following intake form is crucially important in making the correct decisions in the direction of treatment. Please answer the following questions as completely as possible ignoring those that do not pertain to your life situation. What is your chief concern at this time?**

**What stressful events have recently occurred? _____**

**_____**

**_____**

**Please check any current symptoms you are experiencing.**

| | | |
|---|---|---|
| **____ Decreased Energy** | **____ Panic Attacks** | **____ Intrusive/Negative Thoughts** |
| **____ Guilt** | **____ Excessive Worry** | **____ Concentration Problems** |
| **____ Sleep problems** | **____ Anxiousness** | **____ Obsessions/Compulsions** |
| **____ Hopelessness** | **____ Worthlessness** | **____ Relational Difficulties** |
| **____ Eating Problems** | **____ Impulsivity** | **____ Hyperactivity** |
| **____ Tearfulness** | **____ Irritability** | **____ Inappropriate anger** |
| **____ Mania** | **____ Delusions/Hallucinations** | |
| **____ Dissociative States** | **____ Increased Alcohol Use** | **____ Use of Illegal Substances** |
| **____ Thoughts of Death/Suicide** | | **____ Self Injurious Behavior** |

**Other Symptoms**

**_____**

**When would you estimate that these symptoms began? _____**

**What has been the course of your symptoms? (i.e. getting better, worse, or staying the same) _____**

**Have you experienced similar symptoms before? ___ When? _____**

**What have you tried that has made the symptoms better/worse? _____**

**What (if any) medications are you taking or have you tried? _____**

**Have you consulted other health professionals concerning your symptoms? _____**

**Do you smoke? Y N Do you consume alcohol? Y N Do you use marijuana? Y N**

**How many drinks per week? _____ How often use marijuana?_____**

**Have you ever used an illegal substance or legal substance illegally? _____**

**If so, please share when and for how long. (Substance use can create or influence depression/anxiety)**_____

**Do you have a supportive/spiritual community? _____ Explain _____**

**Briefly describe your relationships in your family of origin: _____**

_____

**Briefly describe your current significant relationships: _____**

_____

**Have you ever been the victim of abuse or experienced a traumatic event? Y N**

**Explain: _____**

**Have you ever been married before? _____ Explain relationship _____**

_____

**Please share any other information you want me to know before we begin.**

_____

_____

_____

## INFORMED CONSENT

### WHAT IS INVOLVED IN THE COUNSELING PROCESS?

I am a Licensed Professional Counselor in Texas (LPC #62906). I have a B.A. in psychology, M.S. in counseling, and J.D. in law. I have worked in the mental health field since 2004.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. It requires a very active effort on the part of both the client and therapist. In order to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy has shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. Each individual's progress varies. Our first session will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If at any time you feel that the issues discussed have not been resolved to your satisfaction, I will be happy to help you to secure an appropriate consultation with another mental health professional. If you decide to proceed with counseling, usually a session lasts 50 minutes in duration. Some sessions may be longer or shorter depending on your specific needs and treatment goals**.**

### CANCELLATION POLICY:

24-hour advance notice of cancellation is required with the exception of extreme emergencies (accidents, emergency illnesses, etc.) If you do not cancel your appointment per this policy, you will be expected to pay a $70 fee. Fee will be waived at counselor's discretion. Frequent cancellations may result in termination of the counselor-client relationship. If you start heading in this direction, it will discussed by phone or in person before termination occurs.

**Kate Knapp Lengyel suffers from severe, debilitating migraines and may have to cancel a session with less than 24-hour notice. The best way for Kate to reach me for cancellation (may be at late night or early morning hours) is: ☐ Text message ☐ Email ☐ Cell # ☐ Home # By checking this box, I agree to allow Counseling by Kate to leave a message, text, or email for scheduling purposes only.**

### HOW MUCH DOES IT COST? Financial Agreement & Policy

My standard fee for this service is **$150** for an initial session, **$130** for a 60-minute session and **$110** for a 45-minutes session. It is my practice to charge this amount on a prorated basis for additional time in session. I am willing to testify in court if needed but I am not specialized in forensics and being a master's level counselor may not be considered an expert witness. If you become involved in litigation that requires my participation including but not limited to divorce, custody disputes, or cases involved CPS or criminal activity, and due to the complexity and difficulty of legal involvement, I charge $250 per hour for preparation for and attendance at any legal proceedings and $250 per hour for depositions.

Clients' Initials _____ _____ Informed Consent Page 1 of 3

Also, a $1500 retainer will be required up front if court appearances occur. You will be expected to pay for each session's copay, co-insurance or full amount of session at the time it is held, unless we agree otherwise. ***If you have health insurance and wish for the counselor to bill your insurance, you are agreeing to allow counselor to release the necessary information to the insurance company for claims processing which may include case notes, dates of sessions, treatment plans, etc.***

Payment can be made in the form of cash, credit, or personal check. ***Sessions will be discontinued if an outstanding balance develops without the establishment of payment arrangements***. There is a $30 fee for all returned checks and Counseling by Kate may seek legal action if necessary.

**IS WHAT WE DISCUSS CONFIDENTIAL?**

In general, the confidentiality of all communications between a client and a therapist is protected, and I can only release information about our work to others with your ***written*** permission. However, there are a number of exceptions including some legal proceedings. 1) When I have written authorization from the client or, in the case of death or disability, the client's representative; 2) if you waive the privilege by bringing charges against counselor; in the response to a subpoena from the secretary of health; the secretary may subpoena only records related to a complaint or report as required under state law; 3) when I believe someone is an imminent danger to themselves or others; 4) if there are any reports of abuse to a child, elderly or handicapped person. Should such a situation occur, I will make every effort to fully discuss it with your before taking any action***. If the client is a child or adolescent and is engaging in reckless behavior or persistent substance use, we will discuss the situation and I will give him/her the opportunity to inform their parent/guardian in my presence since this constitutes harm to self.*** Understand that confidentiality is not the same as statutory privilege. If I receive a legal subpoena or if you've given permission for exchange of information for insurance purposes, details regarding our sessions may be disclosed. **If you are involved in marital counseling, confidentiality does not include your spouse and is left up to my discretion.** This will be explained further in your initial session. ***If you have health insurance and wish for the counselor to bill your insurance, you are agreeing to allow counselor to release the necessary information to the insurance company for claims processing which may include case notes, dates of sessions, treatment plans, etc.***

I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together.
While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. The laws governing these issues are quite complex. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable**..**



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**CAN I SEE MY RECORDS?**
Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the medical record. Psychotherapy notes are not part of the medical record and these will not be released, as they can be misinterpreted and/or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. I will also provide a written summary of my therapeutic impressions is requested. The fee for this will be a minimum of $50 or the equivalent to the time required to draft this document.

Clients will be charged an appropriate fee for any preparation time required to comply with an information request. **If for any reason I would become unavailable due to illness, injury, or death, please contact Dr. Amir Abbassi, LPC, LMFT 214-223-7497.** Files are shredded seven years after the date of our final session or seven years past a minor's eighteenth birthday.

**HOW DO I CONTACT YOU?**
I can be reached by leaving a message on my voice mail, text message, or email. I will make every effort to return your call within 48 hours. In emergencies, my services should not be used for crisis intervention. You can leave me a message after contacting 911, your physician, the emergency room of your choice, or a licensed mental health facility. ***Email/text is not a reliable or privacy protected form of contact. If you choose to utilize this option, you do so at your own risk. Scheduling or cancellations of appointments are required by phone or text message.*** _____

**GIFTS**
**Please understand due to ethical standards set forth by the state of Texas and my professional associations, it is my policy not to receive gifts.**

**COUNSELING CONTRACT**
I, the client(s) signed below, affirm the accuracy of the personal information provided herein, and have read the information above and agree to the conditions set forth therein. I hereby agree to the following conditions:

1. I read and understand everything within this **Informed Consent**.
2. I understand that I am financially responsible for any fees & agree to the information provided in the **Financial Agreement**.
3. I also acknowledge receipt of **Notice of Policies and Practices to Protect the Privacy of Your Health Information.**
4. I acknowledge that if I utilize text or email communications with my counselor, we may discuss my personal health information. By utilizing these communications, I consent to disclosure through those means.

(Signed)_____ (Date) _____

(Signed)_____ (Date) _____

## Medical Information Release & Communications Authorization Form

Counseling by Kate, LLC (CBK) recognizes that patients have a right to privacy. Consequently our counselors and staff will not disclose personal healthcare information unless the client or his or her authorized representative has properly authorized the release of information.

**_____YES I understand and agree to allow all medical and treatment information to be shared with my spouse / partner whenever I'm not available unless I request otherwise.**

**_____NO I do not authorize any information whatsoever regarding my personal medical treatment and /or any results to my partner.**
I understand that my treatment records for couples counseling will be kept jointly and cannot be released without permission from both Clients.

**Patient Initial: _____ _____**

## CONTACT VIA VOICEMAIL / EMAIL/TEXT MESSAGE AUTHORIZATION:

During the course of your treatment, we will need to contact you periodically with appointment date/times. You may need to contact CBK for problem solving, support, and other pertinent information when the office is closed. CBK uses text messaging and email as an important resource of treatment. However, by consenting to the use of e-mail and/or text messaging with CBK, you agree that:

a) Although CBK will try to read and respond promptly to your e-mails and text messages, CBK staff may not read your e-mail immediately. Therefore, you should not use e-mail or text message to communicate with CBK if there is an emergency or where you require an answer in a short period of time.

b) If your e-mail/text message requires or asks for a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with CBK.

c) You should carefully consider the use of e-mail/text message for the communication of sensitive medical information, such as, but not limited to, information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

d) You should carefully word your e-mail/text messages so that the information that you provide clearly describes the information that you intend to convey.

e) CBK reserves the right to save your e-mail/phone number and include your e-mail/texts or information contained within your e-mail/texts in your medical record.

f) It is the patient's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted or recommended by CBK.

g) Emails and Text messages are not completely secure. CBK will take all necessary precautions to try to protect your privacy through email and text messages. You agree that if you are communicating with CBK through email and text you are agreeing to allow CBK to respond and treat you as needed via those methods. You

also agree to not hold CBK liable for any security breaches that may occur with those means of communication unless there was intentional negligence by CBK.

In an effort to respect your privacy, please indicate your preferences from the list below by initialing next to the options.

_____**Yes: leave a voice message and/or text message on my home phone**, **mobile phone number or email me.**

_____Home phone ( ) _____

_____Mobile phone voicemail ( ) _____

_____Mobile phone text messaging ( ) _____

_____Email _____

_____**No: I do not authorize any voicemails or emails; I will call your office for scheduling and concerns.**

**Yes: I authorized, leave a message on my partner home or mobile phone number.**
Spouse/Partner Name:_____

_____Mobile phone ( ) _____

_____**No I do not authorize leaving messages or emails on my spouse/partners email or phone.**

_____ _____ _____
**Patient Name** **Patient Signature** **Date**

# Counseling by Kate, PLLC

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Licensed Professional Counselor


## Financial Policy

**Please Initial all sections:**

_____All current balances, co-payments, co-insurance and deductibles are **due and payable PRIOR to services** being rendered and is required by your insurance to be paid at each visit. We accept cash, check, VISA, MasterCard, FSA/HAS Accounts. Please be aware that all checks are run electronically at the time of service. We do not accept post-dated checks.

_____**REFERRALS:** If you have a health insurance plan that requires a referral, you will need a referral from your primary care physician to see our specialists. If your insurance requires a referral that is generated through them, you must reach out to your primary care for them to call your insurance. Since we are the specialist, we cannot generate a referral for ourselves. **If we have not received this referral prior to your arrival at our office, your appointment will either be rescheduled or you will be responsible for the entire bill. It is your responsibility to know if a referral is required and to obtain one.**

_____**INSURANCE BENEFITS:** In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial-payment only until such time that the insurance company processes your claim. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility. It is extremely important for you to know your coverage. If you have concerns regarding the cost of mental health services, please discuss this with the therapist PRIOR to your session.

_____**FORMS FEE:** Please allow 5-7 business days to complete all forms that require a therapist signature and medical review (i.e., FMLA, Therapy animal letters, Short-term disability (STD), other extended leave of absence, etc.) The therapist must take the time to fill out the forms, there for each record requested, a $30.00 Forms Fee will be assessed. Each time a correction needs to be made to a form, another Forms Fee will be charged to the account. There is no exception to this rule. Additional medical records request will also have a $30.00 assigned fee.

_____**NO SHOW/CANCELLATION COURTESY:** We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are unable to keep your appointment to allow for other patients to be seen. We understand that emergencies and other situations happen and you may not have 24 hours notice. Please contact our office as soon as possible when you need to reschedule. If you "no show" for an appointment or cancel with less than 24 hours notice, you may be charged a $70.00 fee. This fee may be waived at the discretion of the therapist. Multiple missed appointments may result in our request for you to find another specialist.

_____**RETURNED CHECK FEE:** There is a $35.00 fee for checks returned for any reason and will be added to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

_____**COLLECTION AGENCY:** Please be aware that Counseling by Kate, PLLC utilizes a collection agency for unpaid bills. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance on your account, to include, but not limited to, an additional percentage of your balance and attorney fees. Any patient sent to collections forfeits any future appointments unless the balance is paid in full but may be permanently dismissed from the practice. You also agree that your private demographic and identifying information (name, address, phone number, etc.) will be disclosed to the agency so that they may carry out the collections. You client notes shall never be shared in this process.

_____**PATIENT BALANCE POLICY:** After filing with the insurance company on file, we will mail you a patient statement if you have any outstanding balance. Payment in full is due upon receipt of this statement and is a courtesy from our office. If you have any questions or dispute the balance, it is your responsibility to contact our billing office within 30 days. Accounts past 30 days will be considered past due and will be subject to a 5% monthly late fee (minimum of $5.00 per month) and may be referred to a collection agency. If you are unable to pay the balance due in full, you must contact our billing office to discuss a payment schedule or arrangements. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements.

Patient Name: _____Date: _____

Parent/Guardian Name: _____

Patient Signature: _____(Parent/Guardian if minor)

## Credit Card Authorization

**Name as on card:**_____

**Billing Address:**_____

_____

**Card #:**_____

**Exp. Date:**_____ **Code:**_____

**AUTHORIZATION SIGNATURE**

_____

**My signature authorizes Kate Knapp Lengyel of Counseling by Kate, PLLC to charge my credit card for payment of services rendered.**
**Today's Date:**_____