



COUNSELING BY KATE & ASSOCIATES

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers: Client's Mbl (\_\_\_\_\_) \_\_\_\_\_

Parent's Mbl (\_\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_\_) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

# of Children \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Employment \_\_\_\_\_ SS# \_\_\_\_\_

Driver's License/ID & Issuing State: \_\_\_\_\_

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

Person Responsible for Payment: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_ ID: \_\_\_\_\_

Group #: \_\_\_\_\_ Primary Insured Name \_\_\_\_\_

Primary Insured DOB \_\_\_\_\_ Primary Insured SS# \_\_\_\_\_

Address of Primary Insured (if different than client's) \_\_\_\_\_

Primary Insured Employer \_\_\_\_\_

Emergency Notification:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Counseling by Kate has permission to leave messages and communicate with me through the following methods. I acknowledge these communications may contain personal health information that is protected by Federal Law. I agree to waive these protections for the communications checked below:

mobile phone  minor's mobile phone  emails  text messages  FaceTime  Zoom



I hereby give the office of Counseling by Kate permission to begin services with me or minor child 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 and Good Faith Estimate.**



**Signature**

**Date**

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 stressful events have recently occurred?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

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

**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 *currently* taking?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



Have you consulted other health professionals concerning your symptoms? \_\_\_\_\_

If yes, what are their names/specialties? \_\_\_\_\_

Please mark Yes or No if you are currently doing any of the following items:

Smoke/vape/tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Marijuana \_\_\_\_\_ (if yes, prescribed) \_\_\_\_\_

How often do you use alcohol? \_\_\_\_\_ 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 healthy support system/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/committed relationship before?    Y    N

Explain relationship \_\_\_\_\_

Please share any other information you want me to know:



**INFORMED CONSENT**

**WHAT IS INVOLVED IN THE COUNSELING PROCESS?**

I am a Licensed Professional Counselor in Texas (LPC #62906) and Washington (LMHC #LH60134000). 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. I was licensed as an attorney in Louisiana, Texas, and Washington. I am currently inactive and am not acting in my capacity as an attorney with regards to this case.

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. 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. Everyone’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 60 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 the entire session 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 be 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 and waive HIPAA regarding scheduling via non-confidential means as marked by me.**

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

My standard fee for this service is \$175.00 for the initial intake session; \$150.00 per hour. It is my practice to charge this amount on a prorated basis for additional time in sessions or used to research, read documents, complete any casework for this case and/or any time spent on this case for any other reason.

Clients’ Initials

Informed Consent Page 1 of 4



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 involving CPS or criminal activity, and due to the complexity and difficulty of legal involvement, I charge **\$\$\$300.00 per hour** for preparation for and/or attendance at any legal proceedings including but not limited to depositions, response to attorneys, trial, hearings, preparation for litigation, participation in subpoenas, emails, etc. I also charge a \$150 administrative fee for all copying and printing of documents to be given to counsel if subpoenaed even if those do not end up being delivered to the parties/attorneys due to settlement or any other reason. The fees will be split between the parties if both parties are requesting my services for litigation. However, if one party triggers my services, they will be responsible for the entirety of the costs associated.

Also, a \$3000.00 retainer will be required up front if litigation or preparation for legal matters as indicated above occur from the party who triggered my involvement in litigation or split between the parties if I am mutually requested to participate in litigation. I will notify you if litigation has begun or been requested by counsel in writing. You will be expected to pay the full amount of a session at the time it is held unless we agree otherwise in writing.

Payment can be made in the form of cash, credit, personal check, Venmo or other payment apps. There will be a convenience fee associated with certain forms of payments. ***You are agreeing to waive any confidentiality of information that is required in order to collect payment when utilizing payments other than cash, as any digital means such as payment apps, credit cards, or other online billing may require some personal information to complete the transactions. Also, your initials indicate that you are agreeing to allow personal information to be transmitted as required for collections by a collection agency if you have a balance due on your account for over 180 days.*** [REDACTED]

***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 and collections 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. It will be up the counselor to determine when this rises to the level of self-harm which would require breaking confidentiality.***

Clients' Initials [REDACTED]

Informed Consent Page 2 of 4



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 or signed a consent form for me to speak with attorneys, other professionals, or the court then 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.

### **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 if 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 (based on the above indicated fee schedules) 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/ FaceTime/Zoom are not privacy-protected forms of contact under HIPAA. If you choose to utilize these options, you do so at your own risk. If you contact me by email/text/FaceTime/Zoom, you are waiving health privacy and confidentiality in regard to utilizing that contact method as a way for us to communicate with one another and therefore that information is no longer HIPAA protected because of your waiver of privacy. However, I will do everything reasonable to keep those communications private and protected.***

Clients' Initials

Informed Consent Page 3 of 4



**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 over \$20 in value.

**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 I have completed and agree to the **Communications Authorization** including but not limited to: text message, FaceTime, Zoom or email communications with my counselor, we may discuss my personal health information. By utilizing these communications, I consent to disclosure through those means and understand that is may no longer be covered by HIPAA.
5. I understand the prices for services and have read the **Good Faith Estimate** provided by Counseling by Kate, PLLC. in adherence with the federal **"No Surprises Act"**.
6. I have requested and received explanations on all policies that involve contractual relationships and actions that may violate state and federal laws regarding medical information and contacts.

Client Name printed	Date
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Client/Guardian Signature	Date
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Client #2 Name printed (if applicable)	Date
--	------

Client #2/Guardian #2 Signature (if applicable)	Date
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**Medical Information Release & Communications Authorization Form**

Counseling by Kate, PLLC (CBK) recognizes that clients have a right to privacy and confidentiality under the federal law (HIPAA). I have read the attached HIPAA form and am aware of how it applies to me treatment with CBK. 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.

**COUPLES:** I understand that my treatment records for couples counseling will be kept jointly and cannot be released without permission from both Clients. **Client Initial:** [REDACTED]

**Court Services:** HIPAA and confidentiality does *not* apply to co-parenting, couples counseling, mediation, etc. where both parties are involved. The confidentiality will be limited, and information disclosed as needed based on therapeutic needs determined by the Counselor. Counselor has provided this disclosure to me. **Client Initial:** [REDACTED]

**VOICEMAIL/EMAIL/TEXT MESSAGE/VIDEO CONFERENCING/PHONE CONTACT  
AUTHORIZATION FORM:**

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, phone calls, video conferencing (FaceTime and/or Zoom) and email as an important resource of treatment. However, by consenting to the use of e-mail, phone calls, video conferencing (FaceTime and/or Zoom) and/or text messaging with CBK, you agree that:

- Although CBK will try to read and respond promptly to your e-mails and text messages, CBK staff may not read your e-mail/text 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. If you are in crisis, CALL 911.
- If your e-mail/text message requires or asks for a response, and you have not received a response within a reasonable time period (24 hours) it is your responsibility to follow up directly with CBK.
- You should carefully consider the use of e-mail/text message/phone calls/video conferencing (FaceTime and/or Zoom) 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. If you agree to utilize those means, you are waiving your rights to privacy under HIPAA. However, CBK has basic security measures in place (passwords) to protect your privacy and will honor confidentiality to the best of our abilities.
- You should carefully word your e-mail/text messages/ phone calls/video conferencing (FaceTime and/or Zoom) so that the information that you provide clearly describes the information that you intend to convey.
- 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/phone calls/video conferencing (FaceTime and/or Zoom) in your medical record.
- It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted or recommended by CBK.
- Emails, text messages, phone calls, and video conferencing (FaceTime and/or Zoom) are not completely secure and are not protected under HIPAA. CBK will take all necessary precautions to try to protect your privacy through email, text messages, phone calls, video conferencing (FaceTime and/or Zoom). However, you agree that if you consent to those non-secure means of communication with regards to your protected health information, you are waiving all claims of breach or liability





# COUNSELING BY KATE & ASSOCIATES

against Counseling by Kate, PLLC or its agents/representatives unless there was intentional negligence.

- You agree that if you are communicating with CBK through email, text, phone calls, and/or video conferencing (FaceTime and/or Zoom), you are agreeing to allow CBK to respond and therapeutically treat you as necessary 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 with which you agree to utilize during your treatment.

**Counseling by Kate, PLLC has permission to leave a voice message, have a phone call, conduct phone sessions, have virtual appointments, send and receive text messages, and/or send and receive emails to the items below which I have marked as Y (YES).**

**Please mark "Y" next to the items which you *APPROVE* may be utilized throughout treatment and waive HIPAA compliance and privacy to as indicated above. Please mark "N" (NO) next to the items which you *do not approve* to be utilized.**

Y or N: Home phone ( ) \_\_\_\_\_

Y or N: Mobile phone voicemail ( ) \_\_\_\_\_

Y or N: Mobile phone text messaging ( ) \_\_\_\_\_

Y or N: Email \_\_\_\_\_

Y or N: Video Conferencing (via FaceTime or Zoom or Teams) \_\_\_\_\_

Y or N: Mobile phone voicemail (minor child) ( ) \_\_\_\_\_

Y or N: Mobile phone text messaging (minor child) ( ) \_\_\_\_\_

**Y or N: I authorize CBK to leave a message on my partner's home or mobile phone number including personal medical information protected by HIPAA.**

\*Spouse/Partner Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Client Name printed \_\_\_\_\_ Date \_\_\_\_\_

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Client #2 Name printed (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

Client #2/Guardian #2 Signature (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

**2600 ELDORADO PARKWAY SUITE 230 MCKINNEY, TX 75070**  
• TEL: 360.528.0059 • WWW.COUNSELINGBYKATE.COM



## Financial Policy

Please **READ** and **initial** all sections below:

\_\_\_\_\_ 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/HSA Accounts and Venmo, Cash App, PayPal, or other payment apps. Please be aware that all checks are run electronically at the time of service. We do not accept post-dated checks. There is a \$35 fee for returned checks.

\_\_\_\_\_ **CREDIT CARD ON FILE:** All clients must have a credit card on file in the event of a balance on client's account that exceeds 30 days *AND* no written agreements regarding alternative payment of the balance exist.

\_\_\_\_\_ **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 specialists, 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. (This does not apply to litigation related cases).

\_\_\_\_\_ **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 clients 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 for entire session 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 client 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. Your client notes shall never



# COUNSELING BY KATE & ASSOCIATES

be shared in this process. Some of the information necessary may be protected under HIPAA and you agree that you are waiving that protection as necessary for collections if you do not pay balances for services.

**CLIENT BALANCE POLICY:** After filing with the insurance company on file, we will mail you a client statement if you have any outstanding balance. This can sometimes take 30-60 days. 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.

**ADMINISTRATIVE FEE FOR LITIGATION:** There is a \$150.00 administration fee for copying, printing and/or duplicating files requested by attorneys or the court in anticipation of litigation (including but not limited to subpoenas, mediations, communications with attorneys, etc.). Even if these copies end up not being distributed to the parties or their attorneys. You will be responsible for payment because they were printed/copied.

**CONVENIENCE FEES:** Payment by credit card, PayPal business, and Venmo business/services.

- **\$1.50** Charges from \$0.00-\$50.00
- **\$3.00** Charges from \$51.00-\$100.00
- **3.5%** Charges from \$101.00 and higher

**Please indicate the method that you prefer to utilize for payment of services, copays, coinsurance, deductible payments.**

- Credit card on file
- HSA/FSA Card
- EFT/Check
- Venmo
- Zelle
- Cash App
- PayPal

\_\_\_\_\_

Client Name

\_\_\_\_\_

Client/Guardian Signature

Date

\_\_\_\_\_

Client #2 Name (if applicable)

\_\_\_\_\_

Client#2/Guardian#2 Signature (if applicable)

Date



**MANDATORY**

**Credit Card Authorization Form**

(Must be completed even if you choose a *different* preferred payment method.)

**Name as on card:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_

\_\_\_\_\_

**Card #:** \_\_\_\_\_

**Exp. Date:** \_\_\_\_\_ **CCV Code:** \_\_\_\_\_

**AUTHORIZATION SIGNATURE**

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My signature authorizes Kate Knapp Lengyel of Counseling by Kate, PLLC to charge my credit card for payment of services rendered effective immediately and until I revoke this agreement in writing. Payment shall be collected as soon as services are rendered. If I have a dispute, I will contact CBK in writing to ask for clarifications of the charges. My credit card on file shall be used for to satisfy any balances in accordance with the FINANCIAL POLICY.

**Today's Date:** \_\_\_\_\_



**Good Faith Estimate**

You have been referred to my office for treatment. I’m required by the 2022 No Surprises Act to give you a Good Faith Estimate of the cost of treatment if you are uninsured or don’t want to use insurance for this care. Since we haven't met, and don’t yet know if you want to use insurance for your treatment, the information below is based on “fee for service” (out of pocket) rates.

If you DO intend to use insurance, check with your insurance carrier to find out what your copayment or coinsurance rates will be—they are likely to be much smaller.

Since I have not yet evaluated your difficulties or symptoms, I must at this point estimate your course of treatment based upon the national average for a course of psychotherapy, which is 18 encounters.

This initial estimate is valid for 12 months, but you are entitled to receive an update on this estimate at any time upon request.

**Current ICD-10 diagnosis:** R69 (diagnosis deferred).

**Anticipated treatment:**

- 1 session of CPT 90791 (diagnostic evaluation) at \$175.00
- 18 weekly sessions of CPT 90837 (psychotherapy, 60 minutes) at \$150.00 per hour (prorated based on actual time spent).
- Total of estimated “fee for services” treatment without insurance: \$2875.00

*This is just a rough estimate based on national averages.* The duration of our work together can be longer or shorter depending upon your symptoms, your work between sessions, and your response to treatment. Unless required by a court order (an extremely rare situation), you are free to discontinue treatment at any time, and free to discuss any other modifications to treatment modalities, frequency, or duration. You are ultimately in control of your own healthcare; I am just here to provide help at your request.

**Location of treatment:** All sessions will take place via telehealth or at my office located at 2600 Eldorado Pkwy. Ste 230 McKinney, Texas 75070.

**My identifying information:**

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

**National Provider Identifier:** 1447565486

**Tax ID number:** 46-2326362

I understand the prices for services and have read the **Good Faith Estimate** provided by Counseling by Kate, PLLC. in adherence with the federal “**No Surprises Act**”.

\_\_\_\_\_

Client Name

\_\_\_\_\_

Client/Guardian Signature

Date



## TEXAS HIPAA NOTICE FORM

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

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS INFORMATION IS BEING PROVIDED TO YOU AS REQUIRED BY LAW.

#### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Counseling by Kate, PLLC and its staff may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

“*PHI*” refers to information in your health record that could identify you.

##### “*Treatment, Payment and Health Care Operations*”

- *Treatment* is when Counseling by Kate, PLLC or its staff provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when Counseling by Kate, PLLC and its staff consult with another health care provider, such as your family physician or another psychologist.
- *Payment* is when Counseling by Kate, PLLC and its staff obtain reimbursement for your healthcare. Examples of payment are when Counseling by Kate, PLLC and its staff disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of Counseling by Kate, PLLC and its staff. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within Counseling by Kate, PLLC and its staff such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of Counseling by Kate, PLLC and its staff, such as releasing, transferring, or providing access to information about you to other parties.

#### II. Uses and Disclosures Requiring Authorization

Counseling by Kate, PLLC and its staff may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Counseling by Kate, PLLC is asked for information for purposes outside of treatment, payment and health care operations, Counseling by Kate, PLLC will obtain an authorization from you before releasing this information. Counseling by Kate, PLLC will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes a Counseling by Kate, PLLC psychologist or counselor has made about our conversation during a private, group, joint, or family counseling session, which Counseling by Kate, PLLC has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Counseling by Kate, PLLC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

#### III. Uses and Disclosures with Neither Consent nor Authorization

Counseling by Kate, PLLC may use or disclose PHI without your consent or authorization in the following circumstances:





**Child Abuse:** If, in my professional capacity, a Counseling by Kate, PLLC psychologist or counselor know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, I am required by law to immediately report that knowledge or suspicion to the Texas Department of Family and Protective Services, or as otherwise specified in law.

**Adult and Domestic Abuse:** If a Counseling by Kate, PLLC psychologist or counselor have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, I am required by law to immediately report such belief to the Texas Department of Family and Protective Services, or as otherwise specified in law.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and Counseling by Kate, PLLC will not release this information without written authorization from you or your persona or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

**Serious Threat to Health or Safety:** If a Counseling by Kate, PLLC psychologist or counselor believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, Counseling by Kate, PLLC may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to Counseling by Kate, PLLC an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and a Counseling by Kate, PLLC psychologist or counselor believes you have the intent and ability to carry out the threat, then Counseling by Kate, PLLC is required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

**Worker's Compensation:** If you file a worker's compensation claim, Counseling by Kate, PLLC may be required to give your mental health information to relevant parties and officials.

#### IV. Patient's Rights and Psychologist's Duties Patient's Rights:

*Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Counseling by Kate, PLLC is not required to agree to a restriction you request.

*Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, Counseling by Kate, PLLC will send your bills to another address.)

*Right to Inspect and Copy* – You have the right to inspect or obtain a copy of PHI and in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Counseling by Kate, PLLC may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, Counseling by Kate, PLLC will discuss with you the details of the request process.



*Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Counseling by Kate, PLLC may deny your request. On your request, Counseling by Kate, PLLC will discuss with you the details of the amendment process.

*Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, Counseling by Kate, PLLC will discuss with you the details of the accounting process.

*Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from Counseling by Kate, PLLC upon request, even if you have agreed to receive the notice electronically.

Psychologist’s and Counselor’s Duties:

Counseling by Kate, PLLC is required by law to maintain the privacy of PHI and to provide you with a notice of its legal duties and privacy practices with respect to PHI. Counseling by Kate, PLLC reserve the right to change the privacy policies and practices described in this notice. Unless Counseling by Kate, PLLC will notify you of such changes, however, Counseling by Kate, PLLC is required to abide by the terms currently in effect. If Counseling by Kate, PLLC revises my policies and procedures, Counseling by Kate, PLLC will notify you in writing by mail if you are an active patient. An active patient is someone that is currently being seen or has been seen for services within three months preceding the revision of policies and procedures.

V. Complaints

If you are concerned that Counseling by Kate, PLLC has violated your privacy rights, or you disagree with a decision Counseling by Kate, PLLC made about access to your records, you may contact Dr. James Davidson at Counseling by Kate, PLLC, 7800 Preston Rd. Suite 145, Plano, Texas and/or the Texas Board of Psychology Examiners in Austin, Texas.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy This notice will go into effect on 12-24-2011.

Counseling by Kate, PLLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains. Counseling by Kate, PLLC will provide you with a revised notice by mail if you are an active patient.

I acknowledge receipt of **Notice of Policies and Practices to Protect the Privacy of Your Health Information.**

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Client/Guardian Signature Date