Counseling by Kate, PLLC

Kate Knapp Lengyel, J.D., M.S., LPC, Mediator
Licensed Professional Counselor

Patient 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 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.**

_____ _____

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 message□FaceTime□Zoom

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. 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. 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 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 in regard to scheduling via non-confidential means as marked by me.

HOW MUCH DOES IT COST? Financial Agreement & Policy

My standard fee for this service is **$150** for the initial intake session; **$130** 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 $250 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 is 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 $2000 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.*** _____

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. 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
Clients' Initials _____ _____ Informed Consent Page 2 of 4
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 if I utilize text, 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.

_____
Client Name printed Date

_____
Client/Guardian Signature Date

_____
Client #2 Name printed (if applicable) Date

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

Medical Information Release & Communications Authorization Form

Counseling by Kate, PLLC (CBK) recognizes that patients have a right to privacy and confidentiality under the federal law (HIPAA). 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: _____

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:

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/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.

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 (24 hours) it is your responsibility to follow up directly with CBK.

c) 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.

d) 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.

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/phone calls/video conferencing (FaceTime and/or Zoom) 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, 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 against Counseling by Kate, PLLC or its agents/representatives unless there was intentional negligence.

h) 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 may leave a voice message, have a phone call or phone session and/or text message on my home phone, mobile phone number or email. Please initial next to the options you AGREE to utilize throughout treatment and waive HIPAA compliance and privacy to as indicated above. Please write "NO" next to the items which you do not approve.

_____ (initial) Home phone ( ) _____

_____ (initial) Mobile phone voicemail ( ) _____

_____ (initial) Mobile phone text messaging ( ) _____

_____ (initial) Email _____

_____ (initial) Video Conferencing (via FaceTime or Zoom)

_____ (initial) Mobile phone voicemail (minor child) ( ) _____

_____ (initial) Mobile phone text messaging (minor child) ( ) _____

_____ (initial) **No: I do not authorize any voicemails, video conferencing, texts or emails. I will call your office for scheduling and concerns.**

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:_____

_____Mobile phone ( ) _____

_____ (initial) **NO, I DO NOT authorize leaving texts, voice messages or emails on my *spouse/partners* email or phone. Does not apply to co-parenting, couples counseling, mediation, etc. where both parties are involved. The confidentiality will be limited and disclosed as needed based on therapeutic needs determined by the Counselor.**

_____

Client Name printed Date

_____

Client/Guardian Signature Date

_____

Client #2 Name printed (if applicable) Date

_____

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

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 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 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 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. 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.

_____**PATIENT BALANCE POLICY:** After filing with the insurance company on file, we will mail you a patient 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

Insurance payments:

→ In-Network insurance plans that Counseling by Kate accepts: United Healthcare, Optum Behavioral Health, Multiplan, Oxford, All-Savers, Aetna (only with pre-authorization)

→ The client's insurance plan determines the deductible, copay, coinsurance rates. Counseling by Kate will attempt all pre-authorizations. Counseling by Kate will check your insurance benefits and relay that information to the client.

_____ I understand and agree that pre-authorizations and benefits checks are quotes and not binding until payments from the insurance company are received.

_____ I understand I understand and agree (by my initials) that I am responsible for all payment amounts that are not covered by insurance *AND* that quotes of benefits are not binding.
_____ I understand if Counseling by Kate is out-of-network with my insurance, I will be *solely responsible* for the *private pay rates* listed on www.counselingbykate.com. Counseling by Kate will provide me with a receipt to file with my insurance personally if requested.

→ ***Clients with Blue Cross Blue Shield Insurance (or its affiliates):*** I am no longer taking ***new clients*** with BCBS insurance due to their refusal to increase their rates equal to their competitors. I will be phasing out of all contracts with them over the next 6 months. You can help me stay in-network with BCBS by reaching out to your insurance company and demand that they change this payment policy so that it is feasible for me to continue to be in-network with them.

_____ I understand and agree that I am not billing to my BCBS insurance and understand that I am responsible for the private pay rate for services as published on www.counselingbykate.com
_____ I understand and agree that if I submit claims to BCBS for reimbursement they may pay a portion of the services and I will pay be responsible for the entire remaining balance (if applicable) at the private pay rates.
_____ I understand and agree that my signature and initials on this form creates a contract between myself and Counseling by Kate which supersedes any contracts between Counseling by Kate and BCBS.
_____ I understand and agree that Counseling by Kate, PLLC shall not be considered "in-network" with BCBS, or its affiliates by my initials

_____
Client Name

_____ _____
Client/Guardian Signature Date

_____
Client #2 Name (if applicable)

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

Credit Card Authorization Form

Name as on card:_____

Billing Address: _____

_____

Card #: _____

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

AUTHORIZATION SIGNATURE

_____

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:_____