Kim L. Parker, LCSW
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Office: Compass Counseling Solutions
7026 Belgold Street
Houston, TX 77066

Client (Child) Information and Intake Form

Child's Name:_____Today's date: _____

Child's DOB: _____ Sex: [ ] Male [ ] Female

Email Address: _____

Street Address:_____

City, State, Zip Code: _____

Cell phone: _____ Home/work phone: _____

The Child primarily lives with: [ ] Mom [ ] Dad [ ] Both [ ] Other: _____

Child's background- Who else lives with this client? (Name, Relationship, Age):

_____

_____

_____

EMERGENCY CONTACT INFORMATION (other than contact info above):

Name:_____Home #_____

Relationship to Client:_____ Cell # _____

Please explain in detail why you are seeking counseling at this time (continue on back if needed):

_____

_____

_____

_____

_____

Information for Clients

Client Name:_____ Date:_____

Thank you for choosing me, Kim L. Parker, LCSW, to address your mental health needs. The following information is designed to help you understand what to expect from your experience in therapy. Please read the following and indicate your understanding and acceptance of policies by writing your initials and date in the space provided below.

About Psychotherapy

Because you will be putting a good deal of time, money, and energy into therapy, you should choose a therapist carefully. You should feel comfortable with the therapist you choose, and hopeful about the outcome of therapy. I provide a variety of techniques to facilitate emotional healing and/or positive behaviors. These include Cognitive Behavioral Therapy, Client Centered Therapy, Play Therapy, Parenting Coaching, and traditional "talk" therapy. As new skills are learned and mastered, homework assignments are often designed to assist you in processing the previous session and preparing for the next session. Sessions may include individual time and/or family members.

_____ _____
Initials Date

Psychotherapy sessions are **45-60 minutes** in length, depending on the needs of the client and the flow of the session.

_____ _____
Initials Date

It is important for parents of children in child custody or divorce situations to both attend the first session to give legal authorization for my work, and also to be on the same page regarding the goals of therapy for the child. In the event that both parents cannot show, then the custodial parent must provide a copy of the divorce decree and custody documents prior to me working with your child. My initials below indicate that I understand this policy and have legal rights to authorize mental health treatment for this child.

_____ _____
Initials Date

Please note that it is important to arrive on time for appointments. Late arrival decreases the amount of time available for the session. If you need to reschedule, please give at least 24 hr notice to avoid being charged in full.

_____ _____
Initials Date

It is important that the relationship between a client and therapist remain on a professional level. This is necessary in order for the best therapeutic treatment be provided to the client.

_____ _____
Initials Date

Confidentiality

It is important that great care is taken to insure confidentiality regarding all the information you share in therapy. It is your legal right that sessions and records about you be kept private. There are a few exceptions to keeping your information private:

1. If there is any suspected child or elder abuse, I am required by law to report this suspicion.

2. If you threaten to harm yourself or someone else, and I believe harm will occur, I will release information to prevent harm from coming to anyone.
3. If I am subpoenaed or my records are subpoenaed, I do release the required information to the court.
4. If insurance is being used, the minimal information needed to bill insurance will be disclosed in order to receive payment for services rendered.
5. If there is a payment owed to me for therapy sessions, you will receive a letter, text, or email requesting prompt payment. If payment is not made within 2 weeks, your name, address and the amount owed may be released to a third party for collections. If this is the case, you will be responsible for the amount owed plus any fees incurred in collecting on the debt.

_____ _____
Initials Date

There are two situations in which I might talk about part of your case with another therapist. First, when I am away from the office for more than a week, a fellow therapist may be available to you in emergencies, and will have access only to information needed to meet your needs in an emergency. Of course, the "on- call therapist" is bound by the same laws and rules, as I am to protect your confidentiality.

_____ _____
Initials Date

Second, I may consult other therapists or other professionals about certain aspects of your case in order to provide high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, and they will be told only as much as they need to know to understand your situation.

_____ _____
Initials Date

Communications confidentiality exception:

I understand that not all my communication with my therapist will be secure due to IT hackers, random theft or loss of equipment. This will include communication by emails, by phone, or via texting. My therapist has utilized all passwords necessary to provide extra security when communicating with me via these modalities. By initialing below, I understand the risks associated with the use of these communication modalities and I give my therapist permission to communicate with me via phone, text, or emails.

_____ _____
Initials Date

Fees, Payments, and Billing

Current Intake Assessment fees: $120 for the initial 60-75 minute intake, including your paperwork time.

Individual or family sessions: $110 for 45 to 60 minutes. If paying cash, a sliding scale may be available based on proof of your income. Payments will be made at the end of each session. Other payment or fee arrangements must be worked out before the end of our first meeting.

Telephone consultations are available for private pay clients only: $110.00 per hour, prorated for the time needed. For example, the charge for a 30 minute telephone consultation is $55.00. Please note--unless you are prepaying for a telephone consultation, calls lasting more than 10 minutes require an office appointment. *Of course, there is no charge for calls about appointments or similar business*.

_____ _____
Initials Date

Court Appearances: My focus in providing psychotherapy is on treatment and healing. **It is not my**

intention to become involved in cases that require my testifying in court. However, should this service be needed, forensic or legal work in terms of paperwork, research, preparation, and calls will be billed at my standard rate of $110 per hour. Court appearances will be billed to the client or client's attorney at a rate of **$500 per hour** door to door. **A retainer fee of $1000 is required prior to court appearances**. This will be applied toward the actual charges, with charge over $1,000 being billed to the client, and any overpayment being reimbursed.

Initials Date

You are responsible for seeing that fees for services provided to you are paid. The client agrees to pay in full for services rendered at the time they are provided. Payment will be collected at the end of each session. Payment is due for reports or letters at the next scheduled session after the services are delivered. The **only form of payment accepted for the services listed above is cash or credit/debit card.**

Initials Date

If you are currently covered by an insurance program for which I am an in network contracted provider, I will bill insurance for you. **You are, however, responsible for any co-payment or deductible required by your plan,** and payment must be made at the time services are rendered unless other arrangements have been made. In the event that your insurance company refuses payment for any reason, **payment for services rendered is ultimately your responsibility.**

Initials Date

Cancellation Policy: **You will be charged for cancelled appointments unless you cancel at least 24 hours prior to the appointment time.** Your insurance will not cover charges for cancelled appointments – payment of these charges is your responsibility. The fee for late or non-cancelled appointments is $55.00 per session. This fee will be charged by the end of the missed session. If you are receiving EAP sessions, you may lose one of your authorized sessions if you cancel with less than 24 hours notice. Medicaid Clients will not be charged for missed appointments, but at the second missed appointment may opt to pay the cancellation fee in order to keep their appointment time slot. **All clients who miss two appointments without at least 24 hr notice will have their appointment time released for other clients.**

Initials Date

Credit Card Policy for Private Insurance or Private Pay Clients: I understand that should I give consent for treatment, it may involve short term or long term sessions, which often require appointments to be scheduled on a weekly or biweekly basis. Due to giving my consent to the cancellation policy above, I also give my permission for my credit card information to be stored by my therapist in case of cancellation/no show fees.

Initials Date

Contacting Your Therapist

Because I provide outpatient evaluation and therapy, I cannot promise to be available at all times. I will usually not accept phone calls during a session with another client. Phone messages will be responded to as quickly as possible. Unless it is an emergency, phone calls received between 6:00 PM and 9:00 AM, and on weekends and holidays, will be returned the next business day.

Initials Date

If you have an emergency or crisis and cannot reach me immediately by telephone, you or your family members should call the Harris County Psychiatric Center, the Harris County Mental Health and Mental Retardation Authority, dial 911 or go to the nearest emergency room.

_____ _____
Initials Date

Termination of services

Ideally, the decision to terminate therapy should be a mutual one between the client and therapist. However, there may be times when I discover that I am not the best equipped therapist to address certain situations. Additionally, a client may choose to end therapy at any time for a variety of reasons. In either situation, to the best of my ability, I will assist you in finding another therapist to best meet your needs.

_____ _____
Initials Date

Complaints

I take your mental health very seriously. I make every attempt to provide you with high-quality care. However, if you have a complaint, please bring it to my attention so that we may work together to resolve the problem. It may be that your complaint can be handled at that level. If your complaint involves unethical or illegal practices, or you feel your rights have been violated, you may file a formal complaint and mail it to the *Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369 or* call 1-800-942-5540 to request the appropriate form or obtain more information.

_____ _____
Initials Date

Consent for Services

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" section and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment provided by my therapist, Kim L. Parker, LCSW. I understand that developing a treatment plan with my therapist, and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Kim L. Parker, LCSW. I am aware that I may discontinue my treatment with my therapist, at any time by written notification. I will still be responsible for paying for the services I have already received.

If the client is not of the age of majority, then I grant permission for Kim L. Parker, LCSW, to provide treatment to the minor who I am presenting for service. I hereby attest to being the custodial parent/s or legal guardian of said minor. *My signature below indicates that I have full legal right to authorize psychotherapeutic treatment for said minor.*

I am aware that an agent of my insurance company or other third-party payer, as well as the electronic billing company used by Kim L. Parker, LCSW, may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive from Kim L. Parker, LCSW, is not made by the insurance company, I will be held responsible for payment. I also understand that if payment is not received, my treatment may be discontinued, and a referral would be made to an appropriate agency.

I authorize the release to my insurance company, managed care company, and the billing company used by Kim L Parker, LCSW, any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment on

my insurance. I authorize payment of medical benefits to my mental health provider or supplier for services to be described on my insurance billings.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or adult consenting for client)	Date
Printed name of Client	Date
Signature of Therapist	Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by this business in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", this document explains how your private health information is kept confidential and also under what circumstances it can be disclosed.

Your medical records may be disclosed only for the following purposes:

1. Treatment – the provision, coordination or management of health care and related services by one or more health care providers
2. Payment – the activities performed in order to obtain reimbursement for services, confirming coverage, billing or collection activities, and utilization review
3. Health care operation – the aspects of running this practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service

In addition, de-identified (all identifiable information deleted or changed) health information may be created and distributed in order to meet contract obligations with managed care companies. Minimal personal information may be used in order to provide appointment reminders.

Any other use or disclosure will be made only with your written authorization. You may revoke such authorization in writing. I am required to abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family member, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information.
4. The right to amend your protected health information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.

It is required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. You may request a written copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with Kim L. Parker, LCSW, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. I will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint::

The U.S. Department of Health & Human Services; Office of Civil rights; 200 Independence Avenue, S.W.; Washington, D.C. 20201; (202) 619-0257; Toll Free: 1-877-696-6775.

_____ _____

Client signature of understanding Date

I, Kim L. Parker, LCSW, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

You may take a photocopy of this document for your records and reference.

CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Name of Client: _____ Date of Birth: _____

Member ID/Medicaid #: _____ or SSN: _____

Name of Clinician: *Kim L. Parker, LCSW*

I, _____, authorize *Kim L. Parker, LCSW*, and my insurance company to exchange confidential information regarding my case for the purpose of coordinating and facilitating treatment planning. This release will expire upon termination of treatment, or one year from signed date, whichever one is later.

_____ _____
Signature of Responsible Party/Client Date

NAME OF INSURANCE COMPANY: _____

PHONE OF INSURANCE COMPANY: ( ) _____

FAX OF INSURANCE COMPANY:( ) _____

I, _____, authorize *Kim L. Parker, LCSW*, and my primary care physician (listed below) to exchange confidential information regarding my case for the purpose of coordinating and facilitating treatment planning. This release will expire upon termination of treatment, or one year from signed date, whichever one is later.

_____ _____
Signature of Responsible Party/Client Date

NAME OF PRIMARY CARE PHYSICIAN: _____

PHONE: ( ) _____ FAX: ( ) _____

ADDRESS of PHYSICIAN: _____

_____

[ ] Faxed to PCP on date: _____

This is a strictly confidential patient medical record. Rediscloure or transfer is expressly prohibited by law.