Counseling by Kate, PLLC

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

Licensed Professional Counselor

INTAKE

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: _____

***Emergency Notification*:**

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

I hereby give the office of Counseling by Kate permission to begin services with me for the purpose of counseling, parenting coordination, parent coaching or collaborative law. I also give it permission to exchange any information necessary for services performed. 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 is current parenting plan on file with the court?

_____
_____
_____

Names of children involved in the case and their ages _____

_____

Names of other children living in the home, other siblings (including step/half) of children involved & their ages. _____

_____

Names of other significant adults in the home/daily life and relationship to child. _____

_____

When did the parents first meet? _____ **How long did the relationship last?** _____

What is the current status of the relationship between parents (i.e. amicable, high conflict, hostile, co-parenting, non-speaking, etc.)? _____

_____

What are you biggest concerns for this process? _____

_____

What other professionals are involved besides the parents' attorneys? _____

_____

Describe your current relationship with your children? _____

_____

What are your goals for this process? _____

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

Briefly describe your relationships in your family of origin: _____

Briefly describe your current significant relationships and support systems: _____

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 regards 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 **$175** 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. I am willing to testify in court if needed, but I am not specialized in forensics and being a master's level counselor

Clients' Initials _____ _____ Informed Consent Page 1 of 4

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 of 3.5% if a retainer is collected for litigation. ***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

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

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.

(Signed)_____ (Date) _____

(Signed)_____ (Date) _____

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

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.

_____**Yes: 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.**

_____ _____ _____
Patient Name **Patient/Guardian Signature** **Date**

Financial Policy

Please initial all sections:

_____All current balances, co-payments, co-insurance and deductibles are **due and payable PRIOR to services** being rendered and is required by your insurance to be paid at each visit. We accept cash, check, VISA, MasterCard, FSA/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.

_____**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.

_____**CREDIT CARD FEE:** There is a 3.5% convenience fee that will charged for all credit card payments over $500.00.

Patient Name: _____Date: _____

Parent/Guardian Name: _____

Patient Signature: _____(Parent/Guardian if minor)

Counseling by Kate, PLLC

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

Licensed Professional Counselor

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:_____

2600 Eldorado Parkway suite 230 McKinney, TX 75070

•Tel: 360.528.0059•www.counselingbykate.com

Co-parenting/Reunification Counseling Advisement Form & Contract

Co-Parenting/Reunification Counseling services offered by Counseling by Kate, PLLC focus on reducing parental conflict in order to enhance the children's emotional functioning and facilitate shared parenting. A Co-Parenting/Reunification Counselor is a neutral person to whom parents can turn when in dispute on matters relating to the children. The Co-Parenting/Reunification Counselor will examine a case and follow the orders of the court to assist the parents in compliance with the orders. The Co-Parenting/Reunification Counselor may also assist the parents in enhancing their parenting relationship, resolving disputes, and/or coming up with future agreements and parenting plans.

The role of the Co-Parenting/Reunification Counselor is to help parents to reach successful resolution of disagreements regarding parenting issues themselves. However, the Co-Parenting/Reunification Counselor is also empowered by the parents or by Court Order to make binding recommendations for the parents in the event the parents are unable to agree on solutions. If a court order does not exist to the contrary, the parents agree that the Co-Parenting/Reunification Counselor's decisions will be binding if expressed as such in written form unless or until a court order is in place to the contrary.

Intake

In order to begin services with families, the following must be on file for each adult:
· a completed intake form
· a copy of the court order
· a consent form to speak with other professionals involved
· a signed copy of this contract with initials on each page

Assuming the Co-Parenting/Reunification Counselor agrees to accept the referral, parties will receive an intake questionnaire or may print the form out online. Additional information may be required depending on the order of the Court.

After a case has been accepted for services, parents or their lawyers must then provide any pertinent reports. These may include additional intake information, affidavit material, records regarding either parent, records regarding the children, correspondence, reports, prior assessments, etc. The Co-Parenting/Reunification Counselor prior to setting meetings may review these and the time to review will be charged to the parties.

Meetings

Depending on the specific role established in the order of the court, the Co-Parenting/Reunification Counselor may have joint sessions with the parents, individual sessions with one or both of the parents, sessions involving other relevant family members, meetings with the children, consultation with other family service providers, and home visits as necessary. Generally, these meetings occur weekly during the initial period of services.

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

Unless prohibited by the court order, the Co-Parenting/Reunification Counselor is authorized to interview the child(ren) privately in order to ascertain the child's needs as to the issues. In conducting such an interview, the Co-Parenting/Reunification Counselor will not encourage or facilitate the child(ren) choosing between the parents but may encourage the child to understand they live in two homes.

During the meetings with the parents or other relatives the Co-Parenting/Reunification Counselor may provide education about co-parenting, communication, and child development. The Co-parenting Counselor may coach the parents to better communicate with each other and their child(ren) and may refer the parents to other professionals for additional services.

Reunification Counseling ONLY

Reunification Counseling will focus on reestablishing a healthy relationship between the child(ren) and the parent with whom they have lost a relationship. This will require individual session for the child(ren), reunifying parent, and often the primary parent. Joint sessions between the reunifying parent and child(ren) will occur when the Reunification counselor deems it is appropriate.

Primary parent will NOT cancel sessions scheduled for the child(ren) unless there is documented evidence of illness (fever, vomiting, etc.) or conflict with a sanctioned school event. Primary parent must provide appropriate documentation of these excuses. Primary parent will make Reunification counseling a priority in the child(ren)'s life and therefore sessions must be scheduled weekly (or at direction of the Reunification Counselor) and parent must make sure child(ren) attend these sessions unless otherwise indicated by Reunification Counselor.

Communications outside of Scheduled Sessions

Contact (including text messages, phone, video conferencing, or emails) initiated by the parents that is limited to scheduling of appointments shall not be billed. If the contact is substantive then the party can be billed for the time spent.

Contact (including text messages, phone, video conferencing, or emails) initiated by the parents will be returned at the discretion of the Co-Parenting/Reunification Counselor. Communications outside scheduled sessions should occur in writing via email, text or facsimile.

For communications under 15 minutes in time, the parties shall not be billed. However, if more time is spent then the party seeking the communications may be billed for the time utilized.

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

Confidentiality

By the way of a release, all therapists, attorneys, ad litems, visitation supervisors, physicians, child care providers, educators, and significant others involved, and previous or current evaluators are authorized to disclose information directly to the Co-Parenting/Reunification Counselor. In turn, the Co-Parenting/Reunification Counselor is authorized to discuss significant information with these individuals or service providers in order to assist in the process. This will only be done as necessary for successful completion of the process.

The Co-Parenting/Reunification counselor will also have parties sign a release which allows the Co-Parenting/Reunification counselor to speak with the attorney or court involved with the case regarding any details which may include but are not limited to: issues that cannot be resolved, hindrance to the process by either party, detrimental behaviors or actions, dismissal of parties, withdrawal of Co-Parenting/Reunification counselor and reasons. Co-Parenting/Reunification counselor agrees to only disclose information in the best interest of the family unit and their progress or resolution. This shall be based on the Co-Parenting/Reunification counselor's professional opinion. Communications for this may be done via email, text message, phone call, voicemail or video conferencing and therefore HIPAA privacy information may be unsecured. Unless expressly specified, you are consenting to these means of communications with other professionals and waive all liability against Counseling by Kate, PLLC and its agents unless there was proof of intentional or negligence.

UNLESS EXPLICITLY RESTRICTED BY THE COURT ORDER NAMING THE COPARENTING/REUNIFICATION COUNSELOR. PARTIES MAY AGREE TO WAIVE THE CONFIDENTIALITY REQUIRED IN THE COURT ORDER SO LONG AS THEY BOTH AGREE TO THIS IN WRITING WITH THE COUNSELOR. IF THE PARTIES AGREE TO WAIVE THE CONFIDENTIALITY NAMED IN THE COURT ORDER, THE REST OF THE ORDER WILL STAND IN ITS ENTIRETY AND NEITHER PARTY SHALL USE THIS WAIVER TO TRY TO HAVE THE ORDER THROWN OUT OR NULLIFIED. Initials indicate that you understand and comply with this stipulation _____

Confidentiality does not apply between the two parents and/or children involved in this case. Instead Limited Confidentiality will apply as the Co-Parenting/Reunification counselor may share information as needed for the success of the Co-Parenting/Reunification process. The Co-Parenting/Reunification counselor shall not be liable for breach so long as she believed, in her professional opinion, that sharing information was necessary to the process.

Parties are prohibited from recording sessions electronically without the written consent of the Co-Parenting/Reunification Counselor. The Co-Parenting/Reunification Counselor process requires open and honest communication in order to succeed. Should the counselor decide to utilize electronic and/or tape recordings will be treated as confidential client notes and will be made at the discretion of the Co-Parenting/Reunification Counselor.

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

The Co-Parenting/Reunification Counselor is required to report certain matters, such as incidents of child abuse or threats of physical violence to a child, disabled person or elderly person. Imminent threats of self-harm, harm to others or abuse may also fall into this category. Confidentiality does not extend to these matters by statute.

Emergencies
Co-Parenting/Reunification Case Management is not an emergency service. If an emergency occurs during the time families are receiving Co-Parenting/Reunification Case Management services the parents are to call 911 or other crisis intervention services.

Disruption
While every precaution short of physical intervention will be taken to ensure the safety of Participants a guaranty that no harm will occur during sessions is neither stated nor implied.

Special arrangements may be made to allow for increased security, such as changing arrival times if there is a Protective Order in place and a request by either parent.

Process Regarding Complaints
If either parent is dissatisfied with the performance of the Co-Parenting/Reunification Counselor they can make their opinions known by following these steps to either resolve the issue between them and the Co-Parenting/Reunification Counselor or be assigned a new Co-Parenting/Reunification Counselor:
Step 1: The parent will discuss the problem with the Co-Parenting/Reunification Counselor in a joint session or individual session. They may also reach out via text message, email or voicemail with their concerns.
Step 2: The parent will put their complaint into a written summary of one page or less. The summary is to be reviewed.
Step 3: The parent will request an individual session with the Coordinator in an attempt to work through the difficulties.
Step 4: The parent may request another Co-Parenting/Reunification Counselor.
Step 5: The parent may request that the court appoint another Co-Parenting/Reunification Counselor.

Termination of Services
The Co-Parenting/Reunification Counselor reserves the right to withdraw from the role as Co-Parenting/Reunification Counselor should he or she feel that effective change is no longer occurring. The parents and their respective attorneys will be given two weeks notice of the decision to withdraw. Names of trained professionals competent to assume the role of Counselor will be provided to both parents. The Co-Parenting/Reunification Counselor will continue to act as Counselor until such a time as a smooth transition has been achieved to the new Co-Parenting/Reunification Counselor.

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

Financial Obligations

An initial retainer of $900.00 per party is required unless otherwise agreed upon. Payments may be made with cash, check, or money order or other agreed upon payment method and is due at the beginning of each session and is not charged against the retainer. If counselor agreed to accept credit card payment for the retainer, there will be a 3.5% non-refundable convenience fee. Phone sessions, text/email sessions over 15 minutes, missed appointments, and/or late notice of cancellation fees will be billed to the parents and payment is expected within 7 days of receipt. Checks should be made out to Counseling by Kate, PLLC.

If payment is not made the session will be rescheduled. Payment for the canceled session due to non-payment by either party will be paid by the parent or parents in non-compliance and will be for the entire session fee for the duration the session was scheduled. There is a $30 returned check fee per returned check.

If either parent must cancel, it must be done within 24 weekday business hours of the scheduled appointment. When the appointment is a joint meeting, the canceling party will notify all participants of this change and the date and time of the rescheduled visit. If cancellation is not done within 24 weekday business hours of the scheduled visit, the entire appointment fee will be charged to the canceling party. Payments for the canceled visit must be paid prior to the next scheduled visit.

Business hours are defined as weekday business, non-holiday hours, Monday through Friday, 9:00 a.m. to 5:00 p.m.

Each Parent's Fee Schedule

The rate for Co-Parenting/Reunification Case Management services is $175.00 per hour rounded up to the nearest 15-minute increment. This includes all services of the Co-Parenting/Reunification Counselor including but not limited to reviewing documentation, records management, organization of files, deliberation and issuance of decisions when parents are unable to resolve issues themselves, meetings, correspondences, phone contact, email, text messages, video conferences, and/or consultation with other professionals.

With the exception of individual sessions, charges for the service will be equally divided between the parents unless the Co-Parenting/Reunification Counselor is provided with a certified copy of the divorce decree, court order, or written agreement of the parties that states otherwise. If the judge's order to participate in the program stipulates that only one parent is financially responsible and the other parent cancels without 24-hour notice, the canceling parent is responsible for that charge.

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

There may be other times when, similar to individual sessions, the Co-Parenting/Reunification Counselor deems it appropriate to charge only one parent a particular fee. This determination is solely at the Co-Parenting/Reunification Counselor's discretion. Fees for services including but not limited to phone calls, texts, video conferencing and/or emails specific to that parent will be billed to the parent who initiates the call, text, communications, or necessitates communication from the Co-Parenting/Reunification Counselor unless otherwise directed in the order.

Summary

I understand that the Co-Parenting/Reunification Counselor cannot change the legal custody status of our child(ren). I understand that the Co-Parenting/Reunification Counselor has full discretion regarding program implementation as outlined in this document.

I understand that my participation with a Co-Parenting/Reunification Counselor can be instrumental reducing the conflict between co-parents. I agree to maintain a serious committal to the program by abiding by the guidelines and requirements of the program as noted herein. Further, I agree to maintain scheduled appointments and will not interfere in the process by refusing to attend sessions or frequently rescheduling appointments.

I understand Co-Parenting/Reunification Case Management is an attempt to coordinate and implement a co-parenting plan that addresses current and future issues related to raising children between two homes. Further, I understand Co-Parenting/Reunification Case Management does not involve adult's property, finances, or other issues that do not directly involve co-parenting. However, finances may be discussed when directly relevant to the co-parenting and/or child(ren).

I understand by signing this I am allowing free and open disclosure between the Co-Parenting/Reunification Counselor and each parent, children, lawyers, teachers, Courts or other parties as deemed necessary at the full discretion of the Co-Parenting/Reunification Counselor unless otherwise indicated by court order or in writing.

I understand I if I engage the Co-Parenting/Reunification Counselor in conversation outside of scheduled sessions I will be financially responsible for that time.

I understand that Co-Parenting/Reunification Counselor will be copied on all email/text communications between my coparent and myself until the Co-Parenting/Reunification Counselor advises us to discontinue. This shall be for coaching and communication purposes and to enhance our parenting relationship. I shall not be charged for copying counselor on these communications unless the co-parenting counselor deems it necessary to engage in treatment with me based on these communications. If using Our Family Wizard, parties will add counselor.

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

I understand copies of all correspondence from either parent to the Co-Parenting/Reunification Counselor must be mailed, emailed, or text to the other parent on the same date the information is submitted to the Co-Parenting/Reunification Counselor, with "cc:" noted on the correspondence, unless otherwise specifically addressed per correspondence by the Co-Parenting/Reunification Counselor.

I understand telephone calls, texts and/or emails to the Co-Parenting/Reunification Counselor may be necessary. Prior to calling I agree to attempt to contact the Counselor in writing to address any issues or scheduling. I understand that messages left for the Co-Parenting/Reunification Counselor may take up to 24 business hours to return (or the next business day if on a holiday or weekend), and I will not call more than once per 24-hour period unless I am calling to cancel a previous request for a return call.

I understand if an emergency arises, I am to call 911, child protective services, or a crisis hotline.

I will attempt to resolve disagreements with the other parent whenever possible. I understand, having obtained independent legal advice or upon the order of the Courts, and agree to empower the Co-Parenting/Reunification Counselor to make binding recommendations when both parents are not able to reach resolution over a parenting issue. Such binding recommendations will be consistent with existing Court Orders or when a recommendation conflicts with an existing Court Order, one or both parties will have their lawyers submit a Rule 11 Agreement prior to finalization of any recommendations.

I understand that the Co-parenting Counselor does not offer legal advice or offer legal counsel, and that I am advised to consult with attorneys in order to be properly counseled about my legal interests, rights and responsibilities.

I understand I am to notify the Co-Parenting/Reunification Counselor in writing within 48 hours of any changes in my contact information, legal representation, residency, or occupants of my home.

I understand that we may make joint parenting decisions in our child(ren)'s best interests at any time without the Co-Parenting/Reunification Counselor's assistance. I will notify the Co-Parenting/Reunification Counselor of any agreements reached with the other parent outside of the Co-Parenting/Reunification Counselor process.

I the undersigned and with regard to our child(ren), agree to retain Counseling by Kate, PLLC to facilitate a Co-Parenting/Reunification Counselor for service and conditions as described above.

I agree to not willingly or intentionally file modifications, orders, or requests with the court that are in direct conflict or frustrate the Co-parenting Counseling process and instead will attempt to resolve these issues within the Co-Parenting Counseling setting first as this process cannot be

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com

successful without cooperation, good faith and trust between the parties. If I am unsure, I will contact the Co-parenting counselor to discuss it and determine if will frustrate the process.

I agree that I have disclosed everything to the Co-parenting counselor with regards to current litigation involving myself and/or our child(ren). Any outstanding matters that are being heard by the court have also been disclosed.

I agree that at the end of the process, the Co-Parenting counselor will draft an agreement that outlines everything we have worked out and agreed to during the process. It will be signed by both parties and the Co-Parenting counselor. This document SHALL NOT be confidential with regards to court proceedings and either party may introduce it into legal proceedings as evidence or to get a court order which reflects the agreement. Once

My signature reflects that I will abide by all conditions outlined in this document.

Parent Signature: _____ Date: _____

Witness Signature: _____ Date: _____

2600 Eldorado Parkway suite 230 McKinney, TX 75070
•Tel: 360.528.0059•www.counselingbykate.com