Kathleen M. Bass LPC-S

520 Central Parkway E.

Suite 303

Plano, Texas 75074

817-915-0359

KathleenBassLPC.com

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Client (first, middle, last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex\_\_\_\_\_

Name of Parent(s)(if client is a child)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (city, state, and zip)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cellphone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT

Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Primary Insured on Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s DOB \_\_\_\_\_\_\_\_\_\_

Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE ASSISTANCE PROGRAM

Name of EAP Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many sessions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the Employee? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee’s Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Issue approved for counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following: If “yes” please indicate the family member’s relationship to you in the space provided (i.e. father, grandmother, uncle, sister, etc.)

Alcohol/Substance Abuse Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domestic Violence Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCD Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phobias Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bipolar Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorders Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autism Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADD/ADHD Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/How Often \_\_\_\_\_\_\_\_\_\_\_ Last Taken\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/How Often \_\_\_\_\_\_\_\_\_\_\_ Last Taken\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/How Often \_\_\_\_\_\_\_\_\_\_\_ Last Taken\_\_\_\_\_\_\_\_\_\_\_\_\_

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ADDITIONAL INFORMATION

Do you(minor) have a PCP? \_\_\_Yes \_\_\_No

PCP’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you(minor) been in counseling before? \_\_\_Yes \_\_\_No

Counselor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_\_ Issue:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you enjoy your job /school ? \_\_\_\_\_ Is there anything stressful in your job/school/life ( please

list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you consider yourself to be spiritual or religious ? \_\_\_Yes \_\_\_ No

If “yes” please describe your faith or belief : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What do you consider to be some of your strengths ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What do you consider to be some of your weaknesses ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What do you want to address in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What would you like to accomplish during your time in therapy ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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PATIENT RIGHTS AND RESPONSIBILITES

Introduction and Professional Disclosure

I am a Licensed Professional Counselor and Supervisor. I have 20 + years in the field of Mental Health. I counsel children, adolescents, and adults. I often use play therapy techniques with children, therapeutic activities with all ages. The main therapeutic ideology used, is Cognitive Behavioral Therapy.

Nature of Counseling

Individuals seek counseling to improve the quality of their life or the quality of their children’s life. I will use active listening to understand your views, feelings, and your situation Goals will be set with you and we will work together to achieve those goals.

Effects of Counseling

At any time, you may initiate discussion of possible positive or negative effects of entering, exiting, or continuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life and perspectives. These changes may affect significant relationships, your job, or understanding of yourself. If these changes cause distress, let me know, so that we can process, work together to achieve the best possible results for you.

Client Rights

Some clients only need a few sessions, and others may require months and even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. But please, participate in a termination session. You also have the right to refuse or negotiate any of my suggestions for you or your child.

Consultation with other Professionals

If you would like for me to interface with a previous therapist, a present physician, psychiatrist, or school personnel – please sign a release that enables me to communicate with other professionals.

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Practice Policies

Please take a few minutes to read through these rights and responsibilities so that you have a clear idea of my policies. If you have any questions, please feel free to ask. **Please initial in each space to indicate that you understand and agree to the item.**

\_\_\_\_Counseling is a professional relationship rather than a social one. Our contact will be limited to counseling sessions. In an urgent/emergency – you may contact me on my cellphone 817-915-0359. Please do not invite me to social gatherings, offer me gifts, ask me to write a reference for you, or ask me to relate to you in a way other then the professional context of our sessions. I will not “friend” current or former clients on social media. To protect your confidentiality in public, I will not acknowledge you unless you approach me first.

\_\_\_\_ Both parents must agree to counseling for a minor child.

\_\_\_\_ All clinical services are by appointment only. Appointment times are not always plentiful. So please write down your appointment time in your calendar. If you have to cancel – barring emergencies – I need 24 hour notice.

\_\_\_\_\_If you do not show up for an appointment or cancel your appointment, given less than 24 hours prior notice, you will be charged for the scheduled time at the rate of $80.00 per hour. Charges for “no shows” cannot be billed to insurance companies.

\_\_\_\_\_ There is no charge for telephone calls or texting pertaining to business matters such as scheduling, payment of fees, or insurance related questions. If you need a professional consultation that requires more time – there are 2 alternatives: You may set up a phone conference or request an emergency appointment. The fee for a phone conference cannot be billed to insurance companies. Consultation with other professionals (school, physicians, etc.) are billed at the same rate. Telephone consultations fees – are billed at $15.00 per 15 minutes. In the case of an urgent need, additional appointments can also be arranged.

\_\_\_\_\_ Returned checks will be assessed at a fee of $25.00.

\_\_\_\_\_ For clients who use a managed healthcare plan, you need to be aware of your deductibles, your benefits, and acquire a pre-authorization if it is required to cover your therapy. You are responsible for obtaining the initial authorization from your insurance carrier. I will assist you if additional authorizations are required.

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\_\_\_\_ The fee for court appearance, reports, etc. will be billed at $100.00 an hour. It is understood that travel time, time waiting for the appearance is also billable – and that it is not covered by insurance.

\_\_\_\_ You may leave me non-urgent messages on my cell phone 817-915-0359. I check my phone regularly throughout the day – and return phone calls and texts at those times. You may leave me a message about urgent concerns – but if the concern is potentially life-threatening – DO NOT wait for a call back, but proceed to an emergency room or call your physician immediately.

\_\_\_\_ Privacy and confidentiality are very important to me. Please be aware of the limits of confidentiality. Limits include, but are not limited to cases of possible abuse, threat of harm to self or others, court orders, child custody litigation or filing of a complaint. If you would like me to contact a physician, school, etc. please complete the release of information form. If any records are subpoenaed, I will provide the requested information, whether or not the information is favorable to the undersigned.

\_\_\_\_Children also have the privilege of confidentiality. Please allow your child the opportunity to talk with me about issues openly. Do not ask what they talked about in the session, but allow them to share what they wish. I will share information that is critical (abusive situations or life threatening conditions) or information that the child gives me permission to share.

\_\_\_\_ Please be aware that email transmissions may not be secure. Limit information transmitted via electronic means.

\_\_\_\_ Records are maintained for 5 years after the last counseling session. If I die or become incapacitated, my records will be handled by a designated professional counseling colleague.

\_\_\_\_\_ I have not been trained in custody evaluations. If you feel that you might need these services, I will be happy to refer you to therapists who specialize in this field. I believe it is important that children feel that they have a safe place to talk openly about their feelings. If the content of their sessions then becomes a part of court proceedings, then the child’s confidence has been betrayed.

\_\_\_\_\_ Concerning complaints and grievance, I would like to have the opportunity to address your concerns. However, if you have a grievance that is not resolved, you may file a compliant with the Board of Licensed Professional Counselors, 1100 W. 49th Street, Austin, TX 78756-3183

\_\_\_\_\_ Defamation: By signing this intake and consent form, you agree that you will not make defamatory comment(s) about the undersigned therapist to others or post defamatory commentary about this therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others acting in concert with you, you further consent (by signing this intake and consent form below) to allow the therapist to use confidential information (where necessary) in the legal arena to rebut or defend against such statements, or prosecute claims for the defamation.

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**I voluntarily agree to receive (or agree for my child to receive) mental health care, treatment or services and authorize the undersigned therapist to provide treatment or services as are considered necessary and advisable.**

**I understand and agree that I will participate in the planning of my care (or for my child’s care) and I may stop such care, treatment by the undersigned therapist at any time.**

**By signing this form, I acknowledge that I have read, understood and agree to the conditions, and information it contains, I acknowledge that I may ask questions or seek clarification of anything of anything unclear to me.**

***I look forward to working with you !***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of client or parent (if client is a child) Signature of other parent (if client is a child)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name Printed Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Therapist**

Consent for Treatment

and Limits of Liability

**Limits of Services and Assumption of Risks**:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

**Limits of Confidentiality:**

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

**Duty to Warn and Protect**

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

**Abuse of Children and Vulnerable Adults**

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

**Insurance Providers**

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumptions of risk and limits of confidentiality and understand their meanings and ramifications.

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

Signature (Client’s Parent/Guardian if under 18) Date

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

Signature of 2nd parent Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

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

Client Signature (Client’s Parent/Guardian if under 18) Date

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

Signature of 2nd Parent Date