



Park Cities Child and Family Counseling

CLIENT INFORMATION

Child (Clients) Name: _____ Today's Date: _____

Birth date: _____ Age: _____ Male Female

Parent/Guardian Name(s) : _____

Single Married Re-married Divorced Widowed

If parent is re-married, step-parent Name(s) _____

Is your home the child's primary residence? Yes No

Address _____ City _____ State _____ Zip _____

E-mail _____

Home Phone _____ Cell Phone _____ Work Phone _____

Where would you like me to leave you messages? Home Work Cell None

If there is an emergency at the office and we must cancel your appointment, where should we call? Home Work Cell None

Employer - Mom _____ Occupation _____

Employer - Dad _____ Occupation _____

In the event of an emergency and we are unable to get a hold of you, whom shall we contact?

Name _____ Relationship to Client _____

Work Phone _____ Home Phone _____ Cell Phone _____

Is your child currently in counseling elsewhere? Yes No

If yes, please describe? _____

Has your child ever received counseling or evaluation services? Yes No

If yes, please describe? _____

How were you referred? _____

How did you find us? _____

Why are you seeking Counseling? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Name: _____ Relationship to Client: _____

Birth date: _____ Soc. Sec. # _____ Age: _____

E-Mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone _____ Home Phone _____ Cell Phone _____

Cash, credit cards, or checks are accepted. Any unpaid balance may be turned over to a collection agency if you refuse to remain responsible for your account. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. If you are using your managed care benefits (insurance), you will be responsible for all fees. You will be expected to pay for late cancelled or forgotten appointments (\$120) unless there has been an emergency, or at least notice of cancellation given within 24 hours. Insurance companies do not pay for missed appointment charges. This fee of \$120 must be paid at your next appointment.

X _____
Signature of patient or parent if minor _____ Date _____

OUT OF NETWORK PROVIDER

Park Cities Child and Family Counseling operates as an out-of-network provider giving clients all the necessary paperwork to file their own insurance reimbursements. Generally speaking, most insurance companies will pay a percentage of each session after you meet your deductible. The majority of my clients' insurance companies reimburse them at a 60/40 or 70/30 percentage split. There are three reasons many successful, established mental health professionals do not join insurance panels.

First, there is a great deal of paperwork to submit for in-network benefits, making it an impractical use of the clinician's time. Second, the in-network filing process usually requires a significant breach of client confidentiality. For example, to meet the requirements for in network reimbursement, the counselor must submit an official client diagnosis and an ongoing progress report, treatment plan, etc. Such information requires that the therapist divulge a good deal of personal information about the client, which then becomes part of his or her permanent medical record. Third, insurance panels' fee schedules are well below national averages.

Almost all material discussed in any therapy session is fully confidential, meaning that Park Cities Child and Family Counseling may not disclose personal information about the client to any party without the client's permission. However, there are some important limits to confidentiality of which clients should be aware. Currently, Texas state law requires that mental health professionals contact appropriate authorities if there is suspected child abuse, elder abuse or dependent adult abuse, or if the client represents an imminent threat to himself, herself or others (e.g. the client directly indicates a real and immediate intention of committing suicide or homicide). Please note that some insurance companies require a release of confidential information in order to evaluate coverage. It is important to discuss the possible consequences of such releases with your therapist. This is especially the case when using in-network benefits. This is why Park Cities Child and Family Counseling has chosen not to be on insurance panels. The only way to insure client confidentiality is when a client files claims for their insurance, thereby avoiding situations in which the privilege of therapist-client confidentiality may be called into question.

ABOUT YOUR CHILD'S EDUCATION

Age: _____ Grade: _____ Nick Names: _____ Failure or Held Back? _____

Current School: _____

What do school personnel tell you about your child? _____

Grade	School	Average Grade	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

ABOUT YOUR CHILD'S FAMILY

Relatives	Name	Age/Grade	Does child get along well with this person?	Occupation
Father				
Mother				
Sister(s)				
Brother(s)				
Step Mother				
Step Sister(s)				
Step Brother(s)				
Any other significant person?				
Who lives in the child's home?				

ABOUT YOUR CHILD'S ROUTINE

What kinds of physical exercise does your child get? _____

How much coffee, cola, tea, or other caffeine does your child consume each day _____

Is your child's eating restricted in any way? How? Why? _____

Bedtime: _____ Wake-up Time: _____ Hours of sleep on an average night: _____

Does your child have any problems getting enough sleep? (Please describe fully.) _____

ABOUT YOUR CHILD'S HEALTH

Who is your child's pediatrician? _____ When was the last visit? _____

Any Concerns shared by the doctor? _____

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had. _____

Describe any allergies your child has: _____

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please _____

Is there a history of mental illness in the child's family? If so, please explain: _____

Does any family member have a current or chronic illness? If so, please explain: _____

Anything else you are concerned about? _____

THESE QUESTIONS ARE REGARDING OLDER CHILDREN

Is this child in a gang? Yes No

Has this child used drugs? Yes No

If so, describe which drugs, frequency, age at first use, and amounts _____

Has this child ever been pregnant or fathered a child? Yes No

If yes, please tell what happened with each pregnancy: _____

ABOUT YOUR CHILD'S SYMPTOMS

Please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- | | | |
|---|---|--|
| <input type="checkbox"/> Accident-prone | <input type="checkbox"/> Imaginary playmates | <input type="checkbox"/> Relationships with siblings |
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Immature | <input type="checkbox"/> Relationships with teachers |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Inappropriate sexual behaviors | <input type="checkbox"/> Resists |
| <input type="checkbox"/> Argues | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Responsible |
| <input type="checkbox"/> Assaults | <input type="checkbox"/> Independent | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Bathroom language | <input type="checkbox"/> Inflicts pain on others | <input type="checkbox"/> Rocking or other repetitive movements |
| <input type="checkbox"/> Bigoted | <input type="checkbox"/> Insults others | <input type="checkbox"/> Runs away |
| <input type="checkbox"/> Bossy to others | <input type="checkbox"/> Interrupts | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Breaks rules | <input type="checkbox"/> Intimidated by others | <input type="checkbox"/> School avoiding |
| <input type="checkbox"/> Breaks the law | <input type="checkbox"/> Intimidates others | <input type="checkbox"/> Self-harming behaviors |
| <input type="checkbox"/> Bullied by others | <input type="checkbox"/> Intolerant | <input type="checkbox"/> Sexual preoccupation |
| <input type="checkbox"/> Bullies others | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sexually active |
| <input type="checkbox"/> Cheats | <input type="checkbox"/> Isolates | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Clowns around | <input type="checkbox"/> Lacks organization | <input type="checkbox"/> Slow-moving |
| <input type="checkbox"/> Competition | <input type="checkbox"/> Lacks respect for authority | <input type="checkbox"/> Slow-responding |
| <input type="checkbox"/> Complains | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Smart-alecky |
| <input type="checkbox"/> Complains of feeling sick | <input type="checkbox"/> Legal difficulties | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Compliant | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Social |
| <input type="checkbox"/> Concern for others | <input type="checkbox"/> Likes to be alone | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Conflicts at school | <input type="checkbox"/> Loitering | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Conflicts at home | <input type="checkbox"/> Loss of friends | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Conflicts with friends | <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Suicide talk or attempt |
| <input type="checkbox"/> Conflicts with police | <input type="checkbox"/> Lying | <input type="checkbox"/> Swearing |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Manipulates | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Cruel to animals | <input type="checkbox"/> Masturbation | <input type="checkbox"/> Talks out |
| <input type="checkbox"/> Dares others | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Teased |
| <input type="checkbox"/> Dawdles | <input type="checkbox"/> Moody | <input type="checkbox"/> Teases others |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Mute, refuses to speak | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Threatens |
| <input type="checkbox"/> Dependent | <input type="checkbox"/> Name calling | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Needs for high degree of supervision | <input type="checkbox"/> Tics-movements or noises |
| <input type="checkbox"/> Developmental delay's | <input type="checkbox"/> Negativism | <input type="checkbox"/> Timid |
| <input type="checkbox"/> Difficulties with parent's partner | <input type="checkbox"/> Nervous | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Disobedient | <input type="checkbox"/> New school | <input type="checkbox"/> Uncooperative |
| <input type="checkbox"/> Disrupts family activities | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Uncoordinated |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Noisy | <input type="checkbox"/> Under-active |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Noncompliant | <input type="checkbox"/> Unhappy |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Obedient | <input type="checkbox"/> Unprepared |
| <input type="checkbox"/> Drug sales | <input type="checkbox"/> Obesity | <input type="checkbox"/> Vandalism |
| <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Only younger playmates | <input type="checkbox"/> Violent |
| <input type="checkbox"/> Failure in school | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Wastes time |
| <input type="checkbox"/> Fantasy life | <input type="checkbox"/> Outgoing | <input type="checkbox"/> Wetting/soiling of bed/clothes |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Out-of-seat behaviors | <input type="checkbox"/> Withdraws |
| <input type="checkbox"/> Feelings are easily hurt | <input type="checkbox"/> Overactive | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Fidgety | <input type="checkbox"/> Picks on others | <input type="checkbox"/> Yells |
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Any other characteristics: |
| <input type="checkbox"/> Finger sucking | <input type="checkbox"/> Pouts | _____ |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Prejudiced | _____ |
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Procrastinates | _____ |
| <input type="checkbox"/> Hair chewing | <input type="checkbox"/> Provokes others | _____ |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Rages | _____ |
| <input type="checkbox"/> Hitting | <input type="checkbox"/> Recent move | _____ |
| <input type="checkbox"/> Hostile | <input type="checkbox"/> Refuses | _____ |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Relationships with friends | |
| <input type="checkbox"/> Hypochondriac | | |

SARAH BALINT, M.ED, LPC, RPT, NCC
PROFESSIONAL DISCLOSURE STATEMENT
AND
INFORMED CONSENT

Qualifications: I am a graduate of the University of North Texas. I have my masters in counseling and my specialty is in play therapy. My formal education and experience has prepared me to work with adults, children, adolescents, groups, couples, schools and parents.

Please Initial Each Item:

- _____ I understand that Sarah Balint, M.Ed, is a Licensed Professional Counselor in the state of Texas, a Registered Play Therapist and a National Certified Counselor.
- _____ I understand that Sarah Balint does not provide 24 hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1- or go to an emergency room for assistance.
- _____ I understand that during the time we work together, we will meet weekly for approximately 50 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.
- _____ I understand that our contact will be limited to counseling sessions and phone contact. If a phone consultation is necessary you may call Sarah at 214. 886. 5760. Applicable fees for phone consultation services will apply.
- _____ I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship. While benefits are expected from counseling, specific results are not guaranteed.
- _____ I understand that counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes could be temporarily distressing. Together we work to achieve the best possible results for you.
- _____ I understand that I am in control of the counseling relationship and may choose at any time to end Our therapeutic relationship. If at any time I am dissatisfied with Sarah Balint's services as a therapist, I have a right to let her know. If I do not feel that Sarah may resolve my complaint, I may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.
- _____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first. In order to protect my confidentiality Sarah will not initiate a greeting.
- _____ Should you or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be able to assist you.
- _____ I understand that Sarah Balint is not a psychiatrist, she is a Master's level therapist, and as such can not recommend or prescribe medications but can encourage clients to see an M.D. for a medication evaluation.
- _____ I understand that the fee for an initial session is \$125.00 and \$125.00 for every subsequent session, these fees are for a 45-minute session.

- _____ I understand that all fees are due at the time of service. You must give a 24- hour notice in canceling an appointment or you will be charged a fee of \$120.00 and must be paid at the next scheduled appointment.
- _____ I understand that there is a \$25.00 fee for all returned checks. Additionally I will need to make a cash or money order payment for the returned check and \$25 processing fess. After a returned check, Park Cities Child and Family Counseling may require credit card or cash payment of future appointments.
- _____ I understand that if a returned check is not cleared up in 30 days. Sarah Balint will file a suit with the Dallas County District Attorney's Office.
- _____ I understand that should I subpoena Sarah Balint as a factual case witness or involve her in court-related processes, she charges a retainer fee of \$1,500, with a charge of \$240 every hour she is involved in case preparation, phone calls, travel, and witness time etc.
- _____ I understand that if I do issue Sarah Balint a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.
- _____ I understand that if my child has parents that are divorced and/or part of a joint custody arrangement, I must furnish Sarah with a copy of the custody agreement/ divorce decree.
- _____ I understand that my records and all of our communications become part of the clinical record. Records are the property of Sarah Balint . Adult client records are disposed of seven (7) years after the client has stopped receiving services. Child client records are disposed of seven (7) years after the client's 18th birthday.
- _____ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:
- o You or your child is a danger to self or someone else.
 - o In situations of suspected child, spouse, or elder abuse, it is the legal duty of the mental health provider to notify medical, legal, or other authorities.
 - o You or your child discloses sexual contact with another mental health professional.
 - o If you or your child is involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
 - o Sarah Balint is ordered by a court to disclose information.
 - o You direct Sarah Balint in writing to release your records.
 - o Sarah Balint is otherwise required by law to disclose information.

By your signature below, you are indicating that you have read and understand the above statements.

Client's Signature

Date

This is for you to read, understand, sign, and keep for your records.

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Notice of Privacy Practices

Park Cities Child and Family Counseling
Dallas, Texas

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

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by you.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services.

You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of March 1, 2007.

THIS IS YOUR COPY TO KEEP

Acknowledgement of Receipt Of Notice of Privacy Practices
For
Park Cities Child and Family Counseling

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

Patient: _____ Date: _____
(If patient is a minor, Parent or guardian must sign)

Consent For use and Disclosure of Health Information

I hereby permit Park Cities Child and Family Counseling to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

Patient Signature: _____ Date Signed: _____
(Parent or Guardian if Patient is a Minor)

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.



Park Cities Child and Family Counseling

CREDIT CARD AUTHORIZATION FORM

I authorize Park Cities Child and Family Counseling to process the listed credit card for payment for services. The credit card will be billed within 48 hours of service.

Type of Credit Card:

Visa Master Card Amex Discover

Name on Card: _____

Number on Card: _____

Expiration Date: ____/____

Billing Address

Address: _____

City: _____ State: _____ Zip: _____

I agree that the above information is true and understand that my card will be charged and I will be responsible for the fees.

SIGNATURE

DATE

PRINTED NAME