



Park Cities Child and Family Counseling

CLIENT INFORMATION

Clients Name: _____ Today's Date: _____

Birth date: _____ Age: _____ Male Female

Single Married Re-married Divorced Widowed

If married, spouses name(s) _____

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 - Self _____ Occupation _____

Employer - Spouse _____ 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 _____

Are you currently in counseling elsewhere? Yes No

If yes, please describe? _____

Have you 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.

ALL ABOUT YOU

About Your Education:

Where did you attend public school? _____

Did you attend college? When, where? _____

Any plans to further your education? ____ If so, when and what? _____

About Your Relationships:

Please list your marriage(s) or other important significant other relationships

	Spouses Name	Year Begun	Year Ended	Married to this Person?	Children from this relationship and their ages?
#1					
#2					
#3					

Please list all the people who live with you:

About Your Family:

Relative	Name	Living	Current age, or age at death	Deceased? Yes or No?	Occupation
Father					
Mother					
Sister(s)					
Brother(s)					
Any other significant person?					

About Your Health:

Who is your Doctor? _____ Last Visit: _____ Concerns? _____

Do you have any chronic medical concerns? _____. If so, please list: _____

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had:

List *all* medications or drugs (legal or illegal) you take or have taken in the last year.

ABOUT YOUR CONCERNS

Please mark all of the items below that currently apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- | | | |
|---|--|--|
| <input type="checkbox"/> Abuse-emotional | <input type="checkbox"/> Headaches, pains | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Abuse-neglect | <input type="checkbox"/> Health | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Abuse-physical | <input type="checkbox"/> Hostility | <input type="checkbox"/> Self Abuse-burning |
| <input type="checkbox"/> Abuse-sexual | <input type="checkbox"/> Impulsive spending | <input type="checkbox"/> Self Abuse-cutting |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Self Abuse-other |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Indecision | <input type="checkbox"/> Self Abuse-scratching |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Self-centeredness |
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Inhibitions | <input type="checkbox"/> Self-control |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Interpersonal conflicts | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Career concerns | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Self-neglect |
| <input type="checkbox"/> Childhood issues (your own
childhood) | <input type="checkbox"/> Irritability | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Children-care | <input type="checkbox"/> Judgment problems | <input type="checkbox"/> Sexual conflicts |
| <input type="checkbox"/> Children-custody | <input type="checkbox"/> Laziness | <input type="checkbox"/> Sexual desire differences |
| <input type="checkbox"/> Children-management | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Sexual dysfunctions |
| <input type="checkbox"/> Choices I have made | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Sexual (other issues) |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Losses | <input type="checkbox"/> Sleep-insomnia |
| <input type="checkbox"/> Compulsive spending | <input type="checkbox"/> Low energy | <input type="checkbox"/> Sleep-nightmares |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> Sleep-too little |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Low income | <input type="checkbox"/> Sleep-too much |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Low mood | <input type="checkbox"/> Step parenting |
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Marital coldness | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Debt | <input type="checkbox"/> Marital conflict | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Marital distance | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Marital infidelity/affairs | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Dependence | <input type="checkbox"/> Medical concerns | <input type="checkbox"/> Temper problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Tension/Stress |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Menopause | <input type="checkbox"/> Thought-disorganization |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Threats of violence |
| <input type="checkbox"/> Drug Abuse-over-the counter
medications | <input type="checkbox"/> Mixed feelings | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Drug Abuse-prescription
medications | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Drug Abuse-street-drugs | <input type="checkbox"/> Motivation | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Drug Abuse-Alcohol | <input type="checkbox"/> Mourning | <input type="checkbox"/> Work Problems |
| <input type="checkbox"/> Eating-poor appetite | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Weight and diet issues |
| <input type="checkbox"/> Eating-making myself vomit | <input type="checkbox"/> Outbursts | <input type="checkbox"/> Withdrawal, isolating |
| <input type="checkbox"/> Eating-overeating | <input type="checkbox"/> Oversensitive to criticism | <input type="checkbox"/> Employment problems |
| <input type="checkbox"/> Eating-under-eating | <input type="checkbox"/> Over-sensitive to rejection | <input type="checkbox"/> Employment- lack of |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Panic or anxiety attacks | <input type="checkbox"/> Employment- overdoing |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Parenting | <input type="checkbox"/> Employment-terminations |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Other Concerns: |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Pessimism | _____ |
| <input type="checkbox"/> Financial troubles | <input type="checkbox"/> Phobias | _____ |
| <input type="checkbox"/> Friendship problems | <input type="checkbox"/> Physical problems | _____ |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> PMS | _____ |
| <input type="checkbox"/> Goals not being met | <input type="checkbox"/> Poor selfcare | _____ |
| <input type="checkbox"/> Grieving | <input type="checkbox"/> Procrastination | _____ |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Relationship problems | _____ |
| | <input type="checkbox"/> Relaxation | _____ |
| | <input type="checkbox"/> Re-marriage | _____ |
| | <input type="checkbox"/> Risk taking | _____ |

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 45 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.

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.

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MENTAL STATUS INFORMATION

Are you currently thinking about suicide or harming yourself in any way? Yes No

Have you had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? Yes No

Are you having any thoughts about harming anyone else in any way? Yes No

STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge.

Client Signature or Parent/Guardian (if minor)

Date

Signature of Minor

Date

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