Kathy S. Scalise M.Ed. LPC
413 West Bethel Rd #100
Coppell, Texas 75019
(972) 393-1596 ext. 24

Welcome New Clients!

Just a few words about my practice as I look forward to working with you…

I am an independent, licensed practitioner of counseling. I will work with you to provide individualized service which is appropriate for your needs. I am licensed by the State of Texas to provide counseling. My undergraduate degree was completed at the University of Texas at Dallas. My graduate studies were completed at the University of North Texas. I specialize in treating adults, adolescents and children 5+. My areas of interest are: depression, anxiety, stress, parenting, couples, health issues-including but not limited to cancer, family therapy, death and dying, grief and loss, and gay and lesbian issues. I would be happy to discuss my professional experience or credentials with you at your request.

Practice Policies

Clients are seen by appointment only. Sessions will usually last 45 minutes, unless more time is agreed upon in advance. If you wish to change our appointment or cancel, please give at least 24 hours notices. Allowances will be made for emergencies, but be mindful that you may be charged full fee for missed appointments. My fee is $125.00 per session, unless we have agreed upon insurance coverage or have made other arrangements. You are responsible for any authorization, fees or copays at each visit. I accept checks or cash for payment. I will provide you a receipt for a third party reimbursement, if requested.

I may be reached 24 hours a day at (972) 393-1596 ext. 24 through voicemail. I generally see clients on Monday, Tuesday and Wednesday. I will return calls as soon as it is feasible. I will not interrupt sessions to return calls. At times, there will be another therapist "on call" to cover my absence. If you have any complaints about my service to you, I invite you to discuss them with me at once. This process may enhance the therapeutic experience and your progress. If you would like to make a formal complaint, please contact:

Texas State Board of Examiners of Professional Counselors
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369
E-mail: lpc@dshs Telephone: (512) 834-6658 Fax: (512) 834-6789

KATHY S. SCALISE, M.Ed., LPC, BCIA-C
Licensed Professional Counselor

Phone: 972-393-1596 Ext. 24
413 W. Bethel Rd., Ste. 100 Fax: 972-304-0400
Coppell, Texas 75019 kathyscounseling@me.com

INTAKE FORM

DATE: _____
REFERRED BY: _____

Client Information:

Name: _____ Age: _____
Street Address: _____ DOB: _____
City/State/Zip: _____ SS#:_____
Phone (Home) _____ (Cell)_____
Phone (Work) _____
Employed by: _____
Occupation: _____
Primary Care Physician (Name/Address/Phone) _____

Person Financially Responsible for Account:
(If different from above)
Name: _____
Street Address: _____
City/State/Zip: _____
Phone: _____

I understand that I am responsible for payment of all charges to this account, not the insurance company. I understand that the therapist's charges may exceed any insurance amount of insurance reimbursement. I also understand that the office visits are payable at the time of service, unless special credit arrangements have been made in advance. In the event that partial or no insurance benefits are available, a flexible payment schedule can be established for your convenience including cash pay.

You will be charged $125.00 (the amount of a 45 minute session) for any appointment made and not cancelled 24 hours in advance.

_____
Signature of Client

BACKGROUND INFORMATION

MEDICATION INFORMATION:

Are you currently taking any medications? Yes _____ No_____
If yes, please list the types, dosage and prescribing physician(s):

_____
_____
_____

Have you ever seen a Counselor in the past, if so give the dates of treatment?

_____
_____

FAMILY IFORMATION:

Mother's Name/Age:

_____
(If deceased, give year died, age at time of death, and cause of death)
Father's Name/Age:

_____
(If deceased, give year died, age at time of death, and cause of death)
Stepmother's Name/Age:

_____
(If deceased, give year died, age at time of death, and cause of death)
Stepfather's Name/Age:

_____
(If deceased, give year died, age at time of death, and cause of death)

Siblings Name(s)/ Age(s):

_____
_____

_____

Relationship Status:

Single_____ Couple_____ Divorced_____ Separated_____

Partner's Name and Age: _____

Children's Name(s) and Age(s):

_____
_____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Kathy S. Scalise M.Ed. LPC

Limits of the Therapy Relationship: What Clients Should Know

Psychotherapy is a professional service I can provide to you. Because of the nature of therapy, our relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client *only*. If we were to interact in any other ways, we would then have a "dual relationship", which would not be right and may not be legal. The different therapy professions have rules against such relationships to protect us both.

I want to explain why have a dual relationship is not a good idea. Dual relationships can set up conflicts between my own (therapist's) interests and your (the client's) best interests, and then your interests might not be put first. In order to offer all my clients the best care, my judgment needs to be unselfish and professional.

Because I am your therapist, dual relationships likes these are improper:

- I cannot be your supervisor, teacher, or evaluator
- I cannot be a therapist to my own relatives, friends (or the relatives of friends) people I know socially or business contacts
- I cannot provide therapy to people I used to know socially or to former business contacts
- I cannot have any kind of business relationship with you besides the therapy itself. For example, I cannot employ you, lend to or borrow from you or trade or barter your services (things like tutoring, repairing, child care, etc.) or goods for therapy.
- I cannot give legal, financial, or any other type of professional advice
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. As your therapist, I cannot be your friend. Friends may see you only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers your choices and helps you choose what is best for you. A therapist helps your learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. You should also know that therapists are required to keep the identity of their client's private. Therefore, I may ignore you when we meet in a public place, and I must decline to attend your family's gatherings if you invite me. Lastly, when our therapy is completed, I will not be able to be a friend to you like your old friends.

In summary, my duty as your therapist is to care for you and my other clients, but *only* in the professional role of therapist. Please not any questions or concerns on the back of this page so we can discuss them.

AGREEMENT FOR SERVICES

I, _____. Request that Kathy S. Scalise, M.Ed., LPC, provide counseling, psychotherapy, and/or biofeedback services to me and if applicable to my minor children. Initially, the frequency of these services will be **once per week unless otherwise agreed upon.**

The goals, purposes and techniques of counseling, or biofeedback are to assist clients through the therapeutic relationship and the use of mental health principle, biofeedback or the techniques of talk therapy to achieve mental, emotional, social, educational or career-related development.

I understand that Ms. Scalise will use her best professional efforts in delivering these services. However, I also understand that there are no assurances regarding outcome or results and none have been made to me.

Ms. Scalise's charges are assessed as follows:

Initial intake session charge is $150.00
45 minute follow-up session or phone session charges are $125.00 per session
Fees may be adjusted in the future upon 30 days notice to me.

I agree that fees for services are payable as follows: (check one)

_____ Fees for services are due and payable at the time of each session.
_____ Fees for services are payable by my health care plan except for any deductible or co-payments which are payable at the time of services rendered.

I agree to pay for any scheduled appointments unless I provide Ms. Scalise with notice of cancellation 24 hours in advance. This fee will be $125.00 per 45 minute schedule appointment, not the co-pay amount. I understand that the missed appointment will be noted on the bill, and that, generally, third part payers do not pay for missed appointments.

If Ms. Scalise is requested by me, or subpoenaed by someone else, to testify in any court related proceeding in which I am party, I agree to pay Ms. Scalise's fee of $375/hr for preparation and testifying time (including depositions) and one dollar a page for record photocopying. If Ms. Scalise's testimony is required by another party, she will attempt to obtain payment from that party, however, the ultimate responsibility for payment is mine and I agree to pay all costs and time incurred prior to or at the time of testimony.

Ms. Scalise and any other person, who has an office in the same suite, are practicing as individuals. The arrangement is an office sharing arrangement only and is not a partnership or similar entity.

Violations of the Licensed Professional Counselor Statute or Chapter 681 of the Texas Administrative Code relating to Licensed Professional Counselors, may be reported to the Board of Examiners of Professional Counselors, 1100 W. 49th Street, Austin, Texas 77856-3183, phone 1-800-942-5540.

I have had an opportunity to read this Agreement and I am in agreement with all the provisions contained in the Agreement. I understand that if I have any reservations regarding any provisions, I should not sign this Agreement.

Date:_____ _____
Client

_____
Where applicable, parent of other authorized person

_____
Kathy Scalise, M.Ed., LPC

What to Expect

What we discus in counseling is generally confidential. You will receive another more detailed informational for about confidentiality in counseling relationships. Counseling is a process of self-examination, emotional awareness and growth. You may choose to make changes in your attitude, perceptions, and behaviors as you progress. There is not guarantee that counseling will "cure" you. Counseling issues of concern will require different amounts of time to address and resolve. Research has shown that psychotherapy may contribute to productivity, enhanced self respect, and improved communication in all kinds of relationships. Sometimes the process may be energizing, exhausting or even painful. Emotional healing may become personally enriching, causing you to face conflict in relationship and learn new coping styles. I will do everything possible to provide a positive counseling experience for you. When indicated, you or your family may be referred for additional services; such as a physical examination by your physician, medication, evaluation, or other types of therapy or support groups. We will discuss those options during your sessions. If I cannot provide the professional care you need or you would like to consult another counselor, I will be happy to refer you to someone who may help you with your concerns.

Upon my death or serious illness, your records will be stored with someone, here at the same office address. I generally keep records for 7 years past the date of our last appointment. All questions about your counseling experience will be answered with respect. I do not accept clients that I don't believe that I can help, so I will enter our relationship with optimism about our progress.

Please sign upon your initial visit

_____	_____	_____	_____
Client or guardian	Date	Counselor	Date

The Rights of Clients

1. You have the right to decide not to enter therapy with me. If you wish, I will provide you with the names of other good therapists.

2. You have the right to end therapy at any time. The only thing you will have to do is to pay for any treatments you have already had. You may, of course, have problems with other people or agencies if you end therapy—for example, if you have been sent for therapy by a court.

3. You have the right to ask any questions, at any time, about what we do during therapy, and to receive answers that satisfy you. If you wish, I will explain my usually methods to you.

4. You have the right not to allow the use of any therapy technique. If I plan to use any unusual technique, I will tell you and discuss its benefits and risks.

5. You have the right to keep what you tell me private. Generally, no one will learn of our work without your written permission. There are some situations in which I am required by law to reveal some of the things you tell me, even without your permission, and if I do reveal these things I am not required by law to tell you that I have done so. Here are some of these situations:

a. If you seriously threaten to harm another person, I must warn that person and the authorities.
b. If a court orders me to testify about you, I must do so.
c. If I am testing or treating you under a court order, I must report my findings to the court.

6. If I wish to record a session, I will get your informed consent in writing. You have the right to prevent any such recording.

7. You have the right to review your records in my files at any time, to add to or correct them, and to get copies for other professionals to use.

CONFIDENTIALITY/RELEASE OF INFORMATION

Kathy Scalise recognizes the importance of client communications in the therapeutic and counseling process and agrees to treat information obtained confidentially in accordance with law and professional standards. However, I understand that certain exceptions to confidentiality exist by virtue of law, the rules of evidence, or professional judgment.

I understand that Kathy Scalise may communicate confidential information when permitted or required by law. Some of the exceptions include reporting child or elder abuse, in response to legal proves, in conjunction with legal proceeding including licensing complaints, in connection with billing efforts, or in conjunction with treatment efforts for persons operating under her direction.

I authorize Kathy Scalise to disclose confidential information when required by the code of ethics for professional associations to which Kathy Scalise belongs; or in other circumstances where release appears proper as viewed by Kathy Scalise using her best professional judgment.

I authorized Kathy Scalise to release such information about me which in her opinion is reasonable necessary to protect others from risk of death or serious harm including information regarding HIV or any other sexually transmitted disease. Said information may be released to whoever is reasonable necessary to accomplish protection.

I further understand that information about me must sometimes be disclosed in conjunction with obtaining payment from third parties. I therefore authorize the release of confidential information for the purpose of processing insurance forms or when obtaining payment from other third party payors and I specifically authorize that information to my insurance company _____(list insurance company(s).

I further understand that it may be beneficial in the course of my therapy to release information to **family members** or others, including referring physicians. I therefore, specifically authorize the release of confidential information to the following persons and I authorize each of the following persons to release all information in their possession to Kathy Scalise and discuss the same with her.

1._____
2._____
3._____
4._____

I understand that Kathy Scalise, at some time, may be unavailable due to illness or vacations. At such time, I authorize Kathy Scalise to release information to her substitute.

I understand that Kathy Scalise may at some time sell or transfer her counseling practice. If that occurs, I consent to the transfer of my records to the person to whom the practice is transferred. In the event of Kathy Scalise's death or disability, I consent to the transfer of my records to her personal representative or agent.

The term "information" as used in the release means all information contained in written records and also information known to Kathy Scalise, which may be communicated verbally. By signing this release I give Kathy Scalise permission to release information regarding my minor children.

_____
CLIENT

_____
Where applicable: parent of other authorized person

_____
Kathy Scalise, M.Ed., LPC

Date: _____

Kathy Scalise, M.Ed. LPC

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY/CONFIDENTIALITY PRACTICES

PRACTICE POLICIES

CONSENT TO TREATMENT

By my signature below I, _____, acknowledge that I read, received copies, and understand of the **Notice of Privacy/Confidentiality Practices and Practice Policies** for **Kathy Scalise LPC**.

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

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop counseling with this therapist at any time. The only thing I will be responsible for is paying for services I have already received. I understand that I may lose other services or may have to deal with other problems, if I stop treatment. (For example, if my treatment has been court ordered. I will have to answer to the court)

I know I must contact the therapist to cancel at least 24-48 hours before the time of my appointment. If I do not cancel and do not show up, I will be charged for that missed appointment.

I am aware that an agent with my insurance company or other third party payer may be given information about the type(s), cost(s), dates(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment and seek to collect the fees.

_____ _____

Signature of client (or personal representative) **Date**

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

I, the therapist, have discussed the practice policies and issues above with the client or his/her personal representative. My observation of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Signature of therapist **Date**

For Office Use Only

Kathy Scalise, MEd., LPC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

I may use and disclose PHI without your written authorization, as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment, to consult about your care.

2. Payment: I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment or Employee Assistance Program services.

3. Health Care Operations: I may use and disclose PHI in connection with our health care operations, Employee Assistance Programs, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and may not be used or disclosed without your written authorization, except when legally requested.

2. Marketing Communications: I will not use your health information for marketing communications without your written authorization.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you.

B. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact the **Privacy Officer**, ***Kathy Scalise LPC*** at [413. W. Bethel Rd #100 Coppell, Texas 75019 (972)393-1596 ext.#24. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director or with me.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on April 14, 2003.

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting the Privacy Officer.

Kathy Scalise M.Ed. LPC

Appointment Reminders / Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: _____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Requested password: |__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Your email address: _____

Your cell phone number: _____

Your cell phone carrier (circle one):

Alltel AT&T Boost Mobile Nextel Sprint SunCom

T-mobile Verizon VoiceStream Virgin Mobile (Other) _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via a traditional telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.
(missed appointment fees will still apply)

Your appointment scheduling and reminders are part of your protected health information under HIPAA, so by signing this form, you are acknowledging your waiver of the right to privacy for that information.

Signature _____ Date_____