Therapeutic Connections Counseling Services, PLLC
Erika Meek, M.Ed., LPC, NCC
3550 Parkwood BLVD Suite A-201, Frisco, Texas 75034
Phone: (214)797-7961 Fax: (469)287-4107

Welcome to my office! I thank you for making your first appointment and I look forward to working with you. I would ask that you review and sign this paperwork, where indicated. Please bring all signed paperwork and a copy of your drivers license and current insurance card (if you are having Erika Meek, M.Ed., LPC, NCC file claims with your insurance company).

Respectfully,
Erika Meek, M.Ed., LPC, NCC

Child Information

Child's Legal Guardian Managing Conservator: if the child is not living with both natural parents, both adoptive parents, or only living parent, this practice requires ***a photocopy of the most recent legal document stating custody arrangements. Services will NOT be rendered if no copy is produced.***

Please initial that you have read and understand this paragraph _____

Child's First Name: _____ Child's Last Name: _____

Address: _____ City/State: _____ Zip: _____

Date of Birth: _____ Grade Level: _____ Sex: _____ Male _____ Female

Home phone: _____ Is it ok to leave a message? _____ Yes _____ No

Name of person responsible for payment: _____

Referred by: _____

Primary Physician: _____ Phone:_____

Emergency Contact: _____ Phone: _____

Relationship to Emergency Contact: _____

Parents have: _____ Joint Custody _____Mother has custody _____Father has custody

_____ Other has custody: _____ Can you provide legal documentation? _____ Yes _____ No

Parent/Guardian Information

Mother/Guardian Name: _____ Date of Birth:_____

SSN:_____

Address: _____ City/State: _____ Zip: _____

Contact Number: _____ Is it ok to leave a message? _____ Yes _____ No

Email Address: _____ Is it ok to leave a message? _____ Yes _____ No

Occupation: _____ Employer: _____

Length of Employment: _____

Marital History and Status: ____Never Married ____Currently Married ____Divorced
____Widow Number of Marriages:_____ Number of Divorces: _____

History of emotional/mental health related issues: _____ Yes _____ No

If yes, please explain: _____

History of behavioral/ conduct problems: _____ Yes _____ No

If yes, please explain: _____

History of Suicide Attempts: _____ Yes _____ No

If yes, please explain: _____

History of inpatient psychiatric care: _____ Yes _____ No

If yes, please explain:_____

History of addiction: _____ Yes _____ No

If yes, please explain:_____

History of family violence: _____ Yes _____ No

If yes, please explain: _____

Father/Guardian Name: _____ Date of Birth:_____

SSN:_____

Address: _____ City/State: _____ Zip: _____

Contact Number: _____ Is it ok to leave a message? _____ Yes _____ No

Email Address: _____ Is it ok to leave a message? _____ Yes _____ No

Occupation: _____ Employer: _____

Length of Employment: _____

Marital History and Status: ____Never Married ____Currently Married ____Divorced
____Widow Number of Marriages:_____ Number of Divorces: _____

History of emotional/mental health related issues: _____ Yes _____ No

If yes, please explain: _____

History of behavioral/ conduct problems: _____ Yes _____ No

If yes, please explain: _____

History of Suicide Attempts: _____ Yes _____ No

If yes, please explain: _____

History of inpatient psychiatric care: _____ Yes _____ No

If yes, please explain:_____

History of addiction: _____ Yes _____ No

If yes, please explain:_____

History of family violence: _____ Yes _____ No

If yes, please explain: _____

Insurance Information

_____ Check here if other financial arrangements have been made and Erika Meek, M.Ed., LPC, NCC will not be filing claims on your behalf.

If insurance information is being provided, a valid insurance card and a valid Government picture I.D. must be provided prior the initial intake session. The name on the insurance card must match the name on the I.D. or proof of any name changes must be provided.

Name of Insured: _____ Date of birth of Insured: _____

SSN of Insured: _____Relationship to Client: _____

Insured's Employer: _____ Business Phone: _____

Employer's Address: _____ City/State: _____ Zip: _____

Insurance Company: _____Behavioral Health Phone: _____

Policy Number: _____ Group Number: _____

Claims Address: _____

Social/ Family Information

Please list below any individuals living with the child (primary and secondary households):

Name Sex Age Relationship

_____

_____

_____

_____

_____

Currently involved in a custody dispute? _____ Yes _____ No; If Yes, please explain: _____

_____

If divorced, mark which best describes your relationship with your ex-spouse: _____ Hostile _____ Maddening _____ Frustrating _____ Friendly _____ Great When did divorce occur? _____

Describe the visitation schedule: _____

I UNDERSTAND THAT I MUST PROVIDE ERIKA MEEK, M.ED., LPC, NCC WITH THE MOST CURRENT COURT PAPERS REGARDING CUSTUDY ARRANGEMENTS. INITIALS _____

Medical/ Mental Health History Information

Is your child currently receiving counseling elsewhere? _____ Yes _____ No

Is your child currently receiving psychiatric services? _____ Yes _____ No; if yes, please include name of professional: _____

Has your child been hospitalized for mental health concerns? _____ Yes _____ No; if yes, reason for hospitalization, when and where: _____

Is your child currently being treated by a physician for any medical conditions? _____ Yes _____ No; if so, please describe: _____

_____

Is your child currently taking prescription, over-the-counter or herbal medication? _____ Yes _____ No; if so please list:_____

Risk Assessment

In the last 48 hours has your child reported any thoughts of harming themselves or other(s)?
_____ Yes _____ No ____ Self ____ Other(s)

Has your child ever been suicidal? _____ Yes _____ No; if yes, please describe: _____

_____

Has your child ever engaged in self injurious behaviors (cutting, burning, skin picking, scratching)?

_____ Yes _____ No; If Yes, please explain _____

Are there any guns or weapons in your house? (specify whose and what type): _____

_____

Has a family member or close friend ever committed suicide? _____ Yes _____ No, if Yes, Who? _____

_____

Is there any family history of mental illness or substance abuse? _____ Yes _____ No; if Yes please list relationship and diagnosis: _____

_____

Do you have any reason to believe your child is using any substances? _____ Yes _____ No; if yes, please describe:

_____

Is there any personal history of: Physical abuse _____ Yes _____ No, Sexual abuse _____ Yes _____ No,

Emotional abuse _____ Yes _____ No Has any abuse been reported to authorities? _____ Yes _____ No; If Yes please explain _____

_____

Do you have any reason to believe that your child is sexually acting out or engaging in high risk sexual behavior?

_____ Yes _____ No; If Yes please explain _____

Has your child ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation?)

If so please state under what circumstance:_____

_____

Education

Child's current school: _____

Teacher(s): _____

Has your child met with the school counselor? _____ Yes _____ No

School problems: _____ Academic problems _____ Discipline Problems _____ Social Problems

_____Other:_____

What complaints does your child have about school: _____

Is your child receiving special education services? _____ Yes _____ No; If Yes, please explain: _____

_____

Has your child ever been tested/assessed through the school district? _____ Yes _____ No; ***If Yes, please bring a copy of the results for the counselor to review.***

Behavioral/Emotional

Please check any of the following that are typical for your child:

____ Trouble with friends	____ Frustrated Easily	____ Sad	____ Aggressive
____ Selfish	____Refusing to go to school	____ Guilt/shame	____Fearful
____Separation Anxiety	____Angry	____ Hallucinations	____ Sets Fires
____ Anxiety	____Head Banging	____ Poor Appetite	____Panic Attacks
____Sexual Acting Out	____Hopelessness	____Excessive Masturbation	____ Running away
____ Bedwetting	____ Hurts Animals	____Sick Often	____Blinking/Jerking
____ Imaginary Friends	____ Short Attention Span	____Bizarre Behavior	____Impulsive
____Shy, Timid	____Bullies, Threatens	____Irritable	____Sleeping Problems
____Careless, Reckless	____Lazy	____Slow Moving	____Chest Pains
____Learning Problems	____Soiling	____Clumsy	____Lies Frequently
____ Speech Problems	____ Trouble with Authority	____ Listens to Reason	____Steals
____Skin picking/Scratching	____Stomach Aches	____Cyber Addiction	____Low Self Esteem
____ Suicidal Threats	____Defiant	____Suicidal Attempts	____ Depression
____ Moody	____Talks Back	____Nightmares	____Phobias
____ Sibling Problems	____Gang involvement	____ Thumb Sucking	____Dizziness
____Tics or Twitching	____Oppositional	____Eating Disorders	____Withdrawn
____Over Active	____Over Weight	____Weight Loss	____Worries

____ Other behavioral concerns: _____

_____

_____

Developmental History

Please indicate if the below events were "normal" or "abnormal." Please describe any significant events.

Physical:

- Pregnancy, delivery, feeding, sleeping pattern, weaning, neonatal illnesses: _____
  _____
- Neuromuscular development of speech, motor milestones (sitting, standing, walking, first words, play)
  _____

Behavioral:

- Toilet training and other training- response to discipline and methods used: _____
  _____
- Reactions to beginning daycare or school: _____
- Phobias/ recurring fears: _____
- Habits/ repeated issues (bedwetting, hair pulling, picking, thumb-sucking): _____
  _____

Social Adjustment

- Age appropriate peer relationships: _____
- Age appropriate social etiquette: _____
- Age appropriate involvement to organized groups: _____

Stressors Related to the Child

Please identify if any of the following are a current or past stressor for your child. Please indicate approximate age at the time the stressor occurred and a brief description.

___Chronic illness of family member: _____
___ Family member absent: _____
___ Family members disability/major accident: _____
___ Family members emotional problems: _____
___ Family members suicide: _____
___Parents divorced: _____
___ Death of a pet: _____
___ Sexual assault: _____
___ Other traumatic experiences: _____
_____

Counseling Services

What are the issues for which you are currently seeking counseling assistance? Please describe: _____
_____

What would you like to change about the situations? _____

_____

What have you done to cope with or resolve these issues? _____

_____ Helpful? ____ Yes ____ No

What are some of your child's coping skills? _____

What are some of your child's personal strengths? _____

What are some of the goals you wish to address or achieve in counseling?

1._____ 2._____

3. _____ 4. _____

By signing below, I confirm that the above information is true and correct. I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision **prior** to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. I understand that I have the right to agree to, or to refuse mental health services provided by Erika Meek, M.Ed., LPC, NCC.

My signature below indicates that I am the legal parent/guardian and I have the right to consent to mental health

treatment. My signature below indicates my desire and consent for my child, _____
(Child's Name)

to receive mental health services from Erika Meek, M.Ed., LPC, NCC at Therapeutic Connections Counseling

Services, PLLC.

_____
Printed Name of Client

_____ _____
Signature of Party Financially Responsible/Parent/Guardian Date

_____ _____
Therapist's Signature Date

Therapeutic Connections Counseling Services, PLLC
Erika Meek, M.Ed., LPC, NCC
INFORMED CONSENT

Before you start counseling there are some things that you ought to know. Legally, this information is called "*Informed Consent." Informed Consent* will help you understand better what to expect from your effort at our office, and it will explain some limitations to what we will be doing. **PLEASE INITIAL AFTER EACH SECTION TO CONFIRM THAT YOU HAVE READ AND UNDERSTAND THE PROVIDED INFORMATION.**

Confidentiality: Of course, all of our work together, our conversations, your records, and any information that you give us is protected by something called *privilege.* That means that the law protects you from having information about you given to anyone without your awareness and permission. Our office respects your privacy, and we intend to honor your *privilege*. However, there are some limits to your privilege, some legal exceptions you should understand before we start.

If we believe there is a risk that you might harm yourself or someone else, we may be required to contact the authorities or the other person to give them the opportunity to protect you or the other person. If we have cause to believe that you are abusing children or elderly or disabled people, we are required by law to notify the authorities. Also, if you become involved in any lawsuit in which you claim mental health is an issue, for example, a custody dispute or an injury lawsuit in which you claim compensation for emotional pain or suffering, then the court or the lawyers may insist upon, and may obtain your information from us. Similarly, you would lose the protection of your privilege if you file lawsuit against our office or a complaint with the state licensing board.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. **INITIAL _____**

Records: All of our communications become part of the clinical record. Records are property of Erika Meek, M.Ed., LPC- Therapeutic Connections Counseling Services. If records are subpoenaed, this does not indicate an automatic release of records and we may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the child's best interest. **INITIAL _____**

Services and Office Policies: Clients are seen by appointment only. Sessions will usually last 45-50 minutes, unless more time is agreed upon in advance. If you wish to change your appointment or cancel, please give at least 24 hours notice. Allowances will be made for emergencies, but be mindful that you **may be charged full fee for missed appointments.** Erika Meek, M.Ed., LPC, NCC offers individual and family counseling services and uses the CBT (Cognitive Behavioral) and Individual Psychology (Adlerian) treatment modality. Play therapy services are utilized for children ages 4-12 years. ***Erika Meek, M.Ed., LPC, NCC does not conduct comprehensive evaluations for custody disputes or sexual abuse.*** **INITIAL _____**

This agreement for services will remain effective until ended by agreement between you and Erika Meek, M.Ed., LPC, NCC or you inform the counselor of your decision **prior** to your last visit. If you have missed a scheduled visit and you do not call our office within *seven days*, Erika Meek, M.Ed., LPC, NCC will accept that as your notice that you have terminated this agreement and that you wish to discontinue counseling services. **INITIAL _____**

Our office does not allow counselors to accept gifts from clients or family members of clients. Counselors are not allowed to purchase goods and/or services from clients or family members. Counselors are not allowed to attend any social events or ceremonies by or for the client. If by chance, a counselor sees a client in the community, the counselor will not acknowledge or approach the client in order to respect privacy and confidentiality.

INITIAL _____

Clients may contact Erika Meek, M.Ed., LPC, NCC via phone or email. Text messaging may be used to cancel appointments, reschedule appointments, or to notify the counselor that the client will be late to session. Erika Meek, M.Ed., LPC, NCC will not provide counseling services, guidance or consultation via text messaging.

INITIAL _____

Session Fees: The **initial session fee is $150** and then **each session will be $125,** unless we have agreed upon insurance coverage or have made other arrangements. Payment is due at the time of service. No refunds are given. You are responsible for any authorization, fees or co-pays at each visit. A sliding scale fee is available for clients not using insurance based on client income and application approval. **I accept checks, credit cards, and cash payments.** I will provide you a receipt for third party reimbursement, if requested.
Returned checks that are written to Erika Meek, M.Ed., LPC, NCC that are not honored by your bank for any reason will result in a $25 NSF charge. **INITIAL _____**

Other Fees: While sessions are not conducted by phone, if an emergency phone consultation is initiated by the client, the first 10 minutes are at no charge. However, $25.00 will be billed to your account for each subsequent 15-minute period. If you, or someone else needs a copy of your file or of other records that may be legally necessary, our office charges $.25 per page for copying, plus postage. **INITIAL _____**

No Show and Late Cancel Appointments: All appointments must be cancelled **24 hours in advance.** Same day cancellations or no show to appointments will incur a $50 fee. This policy is not meant to be punitive, but appointment times you schedule are reserved for you at the exclusion of others who may be waiting to see the therapist. Insurance cannot and will not be billed for these charges. If a client is more than 20 minutes late to a session, the session will be considered a no show and the client will need to reschedule the appointment. For after hour emergencies please call 911 or the suicide hotline 1-800-237-Talk or go to your nearest emergency room.

INITIAL _____

Erika Meek, M.Ed., LPC, NCC is here to help you, though is in no way held liable for self-inflicted harm, harm to self, suicide, and other acts of depression or anger. By signing the policies you do not hold Erika Meek or business liable for you or your behaviors. I understand that Erika Meek, M.Ed., LPC, NCC has a duty to warn. Below is a list of people (but not limited to) that she can contact in order to help prevent harm. **INITIAL _____**

Name Phone email

_____

_____

What to expect in Counseling: You should know that counseling is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate problems, but sometimes, especially at first, and as you

get to the root of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel awkward or uncomfortable. Sometimes counseling requires trying new ways of doing things. You will always be free to move at your own pace, however. We will challenge you and your old ways of thinking and doing things, but we cannot offer any promise about the results of the experiences. Your outcome in counseling will depend upon many things. **INITIAL _____**

Commercial Insurance Carriers: Erika Meek, M.Ed., LPC, NCC will file claims on your behalf of the Primary, In-Network insurance carrier you provide. Out of Network insurance claims are also available to be filed by our office. You understand that you are ultimately responsible for any therapy fee(s) not covered by your insurance carrier. Co-pays and any non-covered services are payable at time of service. Court fees will not be filed with your insurance company and are your responsibility. **INITIAL _____**

Court Testimony Agreement: Erika Meek, M.Ed., LPC, NCC is not Forensic Psychologist and conducting witness/testimonial services is not the therapist's area of interest or expertise. If you have a suspicion that your case will be going to court or your need therapist testimony, please let Erika Meek, M.Ed., LPC, NCC know so I can provide you with an appropriate referral source that can meet your needs. **If you require services for court, I recommend that you hire another mental health professional for this purpose.** **INITIAL _____**

Erika Meek, M.Ed., LPC, NCC does not testify in court and that if I am called to testify you, the parent/guardian are aware that harm will be done to the therapeutic alliance between myself and the client and that counseling services may be terminated and referrals to mental health professionals will be provided. Should you subpoena Erika Meek, M.Ed., LPC, NCC with or without approval or involve me in court related processes, you agree to pay a nonrefundable retainer fee of **$2,400.00** that is due at the time a subpoena is served. The charge for court-related services of any kind is **$300.00** per hour rounded to the nearest 15 minute interval including drive and wait time. Fees incurred for these services will not be filed with your insurance company. If a subpoena is issued to me it will be turned over to our attorney and I will consult with that attorney as necessary. You agree to waive Erika Meek's involvement in any legal matters they deem not appropriate for their participation.

INITIAL _____

I UNDERSTAND THAT CERTAIN INFORMATION MAY BE REQUIRED BY THIRD PARTY SOURCES FOR THE PURPOSE OF TREATMENT, PAYMENT (INCLUDING COLLECTIONS OF PAST DUE ACCOUNTS) AND HEALTH CARE OPERATIONS. I HEARBY CONSENT FOR ERIKA MEEK, M.ED., LPC, NCC TO RELEASE MY HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. I HEARBY ASSIGN TO THE PRACTICE ALL BENEFITS/PAYMENTS FOR SERVICES RENDERED TO MY DEPENDENTS AND/OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY MY INSURANCE. MY SIGNATURE BELOW ALSO ACKNOWLEDGES THAT I HAVE READ AND AGREE TO THE CLIENT FINANCIAL POLICY AND THAT I HAVE BEEN PROVIDED ERIKA MEEK'S NOTICE OF PRIVACY PRACTICES. **INITIAL _____**

_____

Printed Name of Client

_____ _____

Signature of Party Financially Responsible/Parent/Guardian Date

_____ _____

Therapist's Signature Date

Erika Meek, M.Ed., LPC, NCC 3550 Parkwood BLVD Suite A-201, Frisco, Texas 75034
Therapeutic Connections Counseling Services, PLLC Phone: (214)797-7961

HIPPA 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. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: You protected health information will be used, as needed, to obtain payment to your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of you therapist's practice. These activities include, but are not limited to, quality assessment activities, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call your by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food or drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

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 **Erika Meek, M.Ed., LPC, NCC** at 3550 Parkwood BLVD Suite A-201, Frisco, Texas 75034 Phone: (214)797-7961. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services at 200 Independence Ave, S.W. Washington, D.C. 20201. Toll Free: (877)-696-6775. I will not retaliate against you if you file a complaint with the Director or with me.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

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

_____ _____

Client signature (Parent/guardian if client is a minor) Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Erika Meek, M.Ed., LPC, NCC- Therapeutic Connections Counseling Services, PLLC 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 related to HMOs, PPOs, managed care organizations, IPAs, or other government or third party payers, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client signature (Parent/guardian if client is a minor) Date

You have the right the request restrictions of 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.

Therapeutic Connections Counseling Services, PLLC
Erika Meek, M.Ed., LPC, NCC

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES
INFORMED CONSENT
CONSENT TO TREATMENT

By my signature below I, _____ acknowledge that I read, received copies and understand the **Notice of Privacy Practices and Practice Policies** for **Therapeutic Connections Counseling Services, PLLC**

I do seek and consent for my child 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 have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services.

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 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 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.

I know I must contact the therapist to cancel at least 24-48 hours before the time of my appointments. 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), date(s), and providers of any services of treatments I receive. I understand that if payment for the services I receive here are not made, the therapist may stop my treatment and seek to collect the fees.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Therapist Signature Date