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

Client Information

First Name: _____ Last Name: _____

Address: _____ City/State: _____ Zip: _____

Date of Birth: _____ SSN: _____ Sex: _____ Male _____ Female

PLEASE CHECK MARK IF IT IS OK TO LEAVE A MESSAGE:

Home phone: _____ ____ Yes ____ No

Cell phone: _____ ____ Yes ____ No

Email address: _____ ____ Yes ____ No

Employer: _____ Length of Employment: _____

Name of person responsible for payment: _____

Referred by: _____

Primary Physician: _____ Phone:_____

Emergency Contact: _____ Phone: _____

Insurance Information

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

If insurance information is being provided, a valid insurance card and a valid Governmental 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

Your current status? ____ Never Married ____ Married ____ Single ____Divorced ____Widowed ____Engaged ____Living Together ____Same Sex Partners

If currently in a romantic relationship, how long have you been in the relationship? _____

On a scale of 1-10 (10 being best) how would you rate the satisfaction of the relationship? _____

Do you have children together? _____ Do you have children from a previous relationship? _____

Please list below any individuals living in your home:

Name Sex Age Relationship

_____

_____

_____

_____

Medical/ Mental Health History Information

Are you currently being treated by a physician for any medical conditions? _____ Yes _____ No; if so please describe:

_____

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

_____

Have you ever seen a Psychiatrist or other mental health provider? _____ Yes _____ No

Risk Assessment

In the last 48 hours have you had any thoughts of harming yourself or other(s)? ____Yes ____No ___Self ___ Other(s)

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? _____

_____

Have you thought or tried to harm yourself in the past? _____ Yes _____ No, If Yes please explain: _____

_____

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

_____

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 _____

_____

Have you ever been involved in any significant legal actions, currently or in the past? (e.g.: lawsuit, probation, parole) _____ Yes _____ No; if Yes please describe circumstance(s): _____

_____

Alcohol - Substance Use Assessment

I use alcohol: _____ Never _____ Little _____ Average _____ A lot _____ Too Much _____ Should Stop

How many drinks containing alcohol do you consume on a typical day that you are drinking?

_____ 1 or 2 _____ 3 or 4 _____ 5 or 6 _____ 7 to 9 _____ 10 or more

I use drugs: _____ Never _____ Little _____ Average _____ A lot _____ Too Much _____ Should Stop

Do you use marijuana or other "street drugs?" (Remember this information is confidential)

_____ Yes _____ No; if Yes what type/quantity/frequency of use: _____

_____

The following have resulted from my use of alcohol/drugs: ___ Traffic violation ___ Black outs ___ Fighting
__ Relationship troubles ___ Academic problems ___ Health problems ___Financial troubles

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? _____

What are some of your 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 my desire and consent to receive mental health services from

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

_____ _____

Printed Client Name Relationship to Client

_____ _____

Signature of Responsible party/parent/guardian 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.

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 intent 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.

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.*

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.

Our office does not allow counselors to accept gifts from clients or family members of clients. Counselors are not allowed to purchase good 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.

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.

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. 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.

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.

No Show and Late Cancel Appointments: All appointments must be cancelled **24 hours in advance.** Same day cancellations incur a $50 fee and no show to appointments will incur a $75 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. Counseling sessions begin at the top of the hour. 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.

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.

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 may things.

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.

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.**

Erika Meek, M.Ed., LPC, NCC does not testify in court and that if I am called to testify you, the client/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 with or without approval or involve me in court related processes, you agree to pay a 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. You agree to waive Erika Meek's involvement in any legal matters they deem not appropriate for their participation.

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.

_____

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
3550 Parkwood BLVD Suite A-201, Frisco, Texas 75034
Phone: (214)797-7961

NOTICE OF PRIVACY PRACTICES---PLEASE KEEP THIS FORM

The privacy of your health is important to me. I will maintain the privacy of your health information and I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so. **You need to understand these rules of confidentiality now, so you don't tell me something as a "secret" that I cannot keep secret.**

A federal law commonly known as the Health Insurance Portability and Accountability Act of 1996, **HIPPA** requires that I take additional steps to keep you informed about how I may use information that is gathered in order to provide health care services to you. As part of this process, I am required to provide you with the attached **Notice of Privacy/Confidentiality Practices** and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information I maintain about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice, please contact: **Erika Meek, M.Ed., LPC, NCC at 214-797-7961.**

NOTICE OF PRIVACY PRACTICES
Therapeutic Connections Counseling Services, PLLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW 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 our privacy practices, our 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 services 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 you, 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. I may disclose PHI if there is a risk of imminent serious harm to yourself or others. I may disclose PHI if you report neglect or abuse of a minor or elderly person or you report sexual misconduct of a physician or therapist. 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, other lawful process or if your records are subpoenaed; 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 records 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 may have the right to request a restriction on PHI used to 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 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 **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.

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.

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 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 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 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 Client or Personal Representative Date

_____ _____
Therapist Signature Date