Katherine Glassey, M.A., LPC
Individual, Child, Adolescent and Family Counseling
Coppell Counseling Center • 413 West Bethel Road, Suite 202 • Coppell, TX 75019
(p) 972-246-8472 • counseling@katherineglassey.com

Client Intake Packet

Hello and welcome to my practice. I thank you for making your first appointment, and I look forward to working with you to accomplish your goals. I ask that you review and complete the following paperwork and bring it with you to your first appointment. Please also bring the following with you to your first appointment: driver's license, insurance card, and if applicable, a copy of the most recent court custody documents if the counseling is for a child or adolescent.

Date of Initial Appointment_____

Client Name_____ Date of Birth_____ /_____ /_____ Age_____

Address _____ City _____ State _____ Zip _____

If client is a minor, Parent/Guardian Name _____

Home Phone _____ OK to leave message? ☐ Yes ☐ No

Work Phone _____ OK to leave message? ☐ Yes ☐ No

Cell Phone _____ OK to leave message? ☐ Yes ☐ No

Email _____ OK to contact by email? ☐ Yes ☐ No

**Please note that email correspondence is not considered to be a confidential means of communication.*

How did you learn of my practice?_____

Adult/Parent/Guardian, please complete the following information:

Occupation _____ Employer _____

Marital Status _____ Spouse/Significant Other/Partner's Name (if applicable) _____

Date of Marriage/Civil Union_____ Previous Marriages/Unions? ☐ Yes ☐ No

How did previous Marriage(s)/ Union(s) end and when? _____

Do you have children or stepchildren? ☐ Yes ☐ No

Names and ages of all children _____

_____

If client is a minor, please complete the following information:

School and Grade level _____

Name of Parent(s) or Guardian(s) _____ Phone_____

Name of Noncustodial/Other Parent _____ Phone_____

Is other Parent/Guardian aware of and supportive of counseling? ☐ Yes ☐ No

Emergency Information:

In case of emergency, contact:

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

Medical Insurance: □ Yes □ No

If Yes, name of primary insurance _____

Insured's Name _____ Client's Relationship to Insured: _____

Contract/Group # _____ Subscriber/Individual ID # _____ Co-Payment: $ _____

Counseling Concerns:

What brought you to therapy at this time?

What do you see as the most important issue(s) you would like to address and when the issue(s) began?

What issues, situations, or other events do you think have contributed to this difficulty?

What have you attempted to do to help yourself with the above-mentioned issues?

How do you manage stress? (hobbies, exercise, interests, social relationships)

Current Functioning:

Please check the items that describe or relate to the concerns mentioned above:

- ☐ Grief
- ☐ Physical abuse
- ☐ Depression
- ☐ Guilt
- ☐ Anxiety
- ☐ Relationship with parent(s)
- ☐ Relationship with child(ren)
- ☐ Nervousness
- ☐ Vocational direction
- ☐ Loneliness
- ☐ Couple problems
- ☐ Despair

- ☐ Sexual concerns
- ☐ Loss of hope
- ☐ Infidelity of self
- ☐ Infidelity of spouse
- ☐ Physical illness
- ☐ Sleeplessness
- ☐ Self-doubt
- ☐ Suicidal thoughts
- ☐ Alcohol
- ☐ Drugs
- ☐ Problems with faith/meaning
- ☐ Other: _____

Have you ever **considered suicide** in connection to your **current** problem? If yes, please give a brief description:

_____

Have you ever **considered suicide** in the **past**? If yes, please give a brief description with dates:

_____

Have you **attempted suicide recently** or in **the past**? If yes, please give a brief description with dates:

_____

Have you had any **homicidal thoughts recently** or in the **past**? If yes, please give a brief description with dates:

_____

Health History:

Primary Doctor: _____ Phone: _____

Date of last physical exam: _____ Reason: _____

At any time have you experienced the following:

Diabetes, arthritis or other chronic illness	☐ Never	☐ Past	☐ Present
Epilepsy or seizure disorders	☐ Never	☐ Past	☐ Present
Heart of blood pressure problems	☐ Never	☐ Past	☐ Present
Gastrointestinal problems	☐ Never	☐ Past	☐ Present
Head injury	☐ Never	☐ Past	☐ Present
Lengthy hospitalization	☐ Never	☐ Past	☐ Present
Speech or language problems	☐ Never	☐ Past	☐ Present
Hearing difficulties	☐ Never	☐ Past	☐ Present
Eye or vision problems	☐ Never	☐ Past	☐ Present
Fine motor/ handwriting difficulties	☐ Never	☐ Past	☐ Present
Gross motor difficulties/ clumsiness	☐ Never	☐ Past	☐ Present
Appetite problems (Overeating or under-eating)	☐ Never	☐ Past	☐ Present
Sleep problems (falling or staying asleep)	☐ Never	☐ Past	☐ Present
Menopause/Menstrual difficulties	☐ Never	☐ Past	☐ Present
Sexual difficulties	☐ Never	☐ Past	☐ Present
Migraines. Other headaches	☐ Never	☐ Past	☐ Present
Alcohol or substance use/ abuse problems	☐ Never	☐ Past	☐ Present
Smoking	☐ Never	☐ Past	☐ Present
Thyroid problems	☐ Never	☐ Past	☐ Present
Other significant health issue(s): _____	☐ Never	☐ Past	☐ Present

List any prescription and over-the-counter medications you presently use for any physical or medical condition. (Include: Medication, dosage, time taken)

_____

_____

_____

How would you rate your current physical health?

How would you rate your current sleeping habits?

Please list any specific health problems you are currently experiencing:

Please list any major health problems, allergies, significant injuries, history of head injury or chronic illness not listed above:

Counseling History:

Have you ever been in counseling before? ☐ Never ☐ Past ☐ Present

If yes, with whom? _____

What was the primary problem for which you sought counseling?

When did counseling occur? _____ For how long? _____

What was the outcome? _____

Have you ever been in a hospital or residential program for emotional or behavioral problems? ☐ Yes ☐ No

If so, when? _____ Where? _____

What was the outcome? _____

Have you ever taken medication(s) for emotional and/or behavioral problems?

☐ Never ☐ Past ☐ Present

List prescription medication you presently use for any emotional and/or behavioral problems:

Who is prescribing these medications?

Substance Abuse:

Have you ever received treatment for substance abuse? ☐Yes ☐No

If yes, when and where? _____

Please check all of the substances you have used, past and present:

	Past	Present		Past	Present		Past	Present
Alcohol	☐	☐	PCP	☐	☐	Ecstasy	☐	☐
Marijuana	☐	☐	Cocaine	☐	☐	Sedatives	☐	☐
Heroine	☐	☐	LSD	☐	☐	Inhalants	☐	☐
Nicotine	☐	☐	Opiates	☐	☐	Barbiturates	☐	☐
Amphetamines	☐	☐	Caffeine	☐	☐	Designer Drugs	☐	☐

Does anyone in the family use alcohol or drugs? If yes, who and what do they use?

_____

Legal History:

Are you currently, or have you ever been, involved with the legal system? ☐Yes ☐No

If yes, for what reason(s)? (truancy, traffic tickets, juvenile offenses, etc.)

_____

Do you anticipate being involved in further legal action in the future (criminal, divorce, custody, visitation rights, civil, etc.)? ☐Yes ☐No

If yes, please explain: _____

Family:

How would you rate your social life?

Very Negative 0 1 2 3 4 5 6 7 8 9 10 Very Positive

How would you rate your current relationship with your significant other or spouse?

Very Negative 0 1 2 3 4 5 6 7 8 9 10 Very Positive

How would you rate your current relationship with your child(ren), if any?

Very Negative 0 1 2 3 4 5 6 7 8 9 10 Very Positive

Annual Family Income: $_____

Religion & Spirituality:

Is religion and/or spirituality important to you or other family members? ☐Yes ☐No

If yes, please describe _____

_____

What losses, changes, crises, and transitions have significantly impacted your life?
(e.g., divorce, arrests, graduation, moves, deaths in the family, etc.)

What do you consider to be some of your personal strengths and resources?

What do you consider to be some of your family's strengths and resources?

Have you or any other person in your family experienced any of the following problems?

Depression	☐ Myself	☐ Other (name/relationship) _____
Neglect	☐ Myself	☐ Other (name/relationship) _____
Sexual Offense	☐ Myself	☐ Other (name/relationship) _____
Financial Difficulty	☐ Myself	☐ Other (name/relationship) _____
Physical Abuse	☐ Myself	☐ Other (name/relationship) _____
Sexual Abuse	☐ Myself	☐ Other (name/relationship) _____
Alcohol/Drug Abuse	☐ Myself	☐ Other (name/relationship) _____
Other Mental Illness	☐ Myself	☐ Other (name/relationship) _____

Is there anything else you believe is important for me to know as we begin our counseling relationship?

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Notice of Privacy Practices and Confidentiality in Therapy

(Please keep this form for your records)

The privacy of your health information 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 know about these rules of confidentiality now so that you can determine what you want to disclose in our work together.**

A federal law commonly known as **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 cervices 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 and questions about this Notice, please contact Katherine Glassey at 972-246-8472 or counseling@katherineglassey.com.

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

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use or disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform

various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI.

Required by Law. Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization:

Abuse and Neglect	**Law Enforcement**
Judicial and Administrative Proceedings	**National Security**
Emergencies	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as fitness for military duties, eligibility for VA benefits, and national security and intelligence)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. I will also obtain an authorization from you before using or disclosing Psychotherapy notes and PHI in a way that is not described in this Notice. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to the Privacy Officer, Katherine Glassey, M.A., LPC, at 413 West Bethel Road, Suite 100, Coppell, Texas 75019:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. If you are the parent or legal guardian of a minor, please note that certain portions of the minor's record will not be available to you. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information, although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised. If there is a breach of unsecured protected health information concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

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Client Rights and Responsibilities and Consent to Therapy

Therapist: My name is Katherine Glassey and I am a Licensed Professional Counselor. I earned my Master of Arts in Marriage and Family Counseling in 2011 from Southwestern Baptist Theological Seminary and earned my Licensed Professional Counselor license in 2014. My formal education has prepared me to counsel children, adolescents, adults, and family systems.

Nature of Counseling: I believe that people grow and change through awareness. I will invite you to explore your feelings and take more responsibility in your life of your thoughts, feelings, behaviors, relationships and combinations of these focal areas. I believe that the people who become my clients are experts on their own lives. Therefore, all goals are collaborative. We will form and work toward steps to reach counseling goals together, as a team. Although I have counseling expertise, I cannot and will not force anyone to change.

Therapeutic Process: The initial assessment appointment is 60 minutes in length. All remaining counseling sessions are 50 minutes in length. My therapeutic approach blends Biblical principles within the framework of strength-based solution-focused therapy. Methods I use in therapy include coaching, teaching, modeling, encouraging, and challenging. Among the techniques used in therapy are questions, scaling, experiential exercises, stories, family exploration, reframing, exceptions, miracle questions, and focusing on patterns. As a parent and adult, you are in complete control of how many sessions that you desire you or your child to have in counseling.

Therapeutic Relationship: Your relationship with me is a professional and therapeutic one. In order to preserve this relationship, it is imperative that I have no other relationship with you outside of therapy. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Ethically, I am not allowed to socialize with my clients, purchase products or services or accept gifts. In the event that our paths cross in social or public settings, our therapeutic relationship comes first. In order to protect your confidentiality, I will not initiate a greeting.

Social Media: I do not accept friend requests from current or former clients on my personal social media platforms due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

Effects of Counseling: At any time you may initiate a discussion of possible positive or negative effects of counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these changes could be temporarily distressing. You may learn things about yourself that you do not like (as well as unearth strengths that you did not know you possess). Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work depends on the quality of effort you are prepared to give this endeavor. Together we will work together to achieve the best possible results for you.

Client Rights: Some clients need only a few sessions to achieve their goals. Others may require several months or even several years of counseling. As a client, you are in complete control of how many sessions you want to have in counseling. That means you can end our relationship at any time. You have a right to refuse to do anything that makes you feel uncomfortable in a session. It is important that my services are rendered in a professional manner. If at any time you are dissatisfied with my services, please let me know.

Fees: My fee for the initial assessment appointment is $120 and then each session after is $100. Payments are due at the time services are rendered. Payment will be received at the beginning of each session and may be made in cash, check or credit card. A fee of $25 is added to returned checks. A reasonable fee will be charged for copies of any records requested by the client. Please understand that if payment for the services is not made, the therapist may stop treatment and seek to collect the fees.

Cancellation: Please give at least 24 hours notice if you need to cancel or reschedule an appointment for any reason. A $75 fee will be charged for a late cancellation less than 24 hours. A $100 fee will be charged for a no-show (full session fee). You are responsible for calling to cancel or reschedule your appointment in a timely manner during normal counseling hours (Monday-Saturday 9:00am – 5:00pm). Late and no-show fees are applied because you make an

appointment to reserve therapeutic time with the therapist. The therapist agrees not to utilize that time slot for any other purpose.

Client Initials _____

Insurance/Third Party Payment for Services: I do accept insurance/third party payments for therapy services. Under most health care plans today (insurance, PPO, HMO, etc.), insurance companies offer partial coverage and/or reimbursement for mental health services. Some HMOs and PPOs may require "preauthorization" before you can receive services. Most insurance agreements make it necessary to assign you with a psychiatric diagnosis in order to be reimbursed or cover partial payment for services. Additionally, some insurance companies may require therapists to submit clinical information about you, such as treatment plans or summary of the issues discussed in therapy. Although insurance companies claim to keep your clinical information confidential, there is no guarantee or control over confidential information shared outside of the therapist's office. If using insurance/third party payments for services, you agree and understand that the therapist may be required to share confidential information about your treatment and diagnosis throughout therapeutic treatment to your insurance provider.

You may file claims with your insurance company for out-of-network benefits and you may be reimbursed directly based on your insurance plan. A receipt with the information necessary for filing a claim can be provided upon request.

Court Related Issues: Although it is my goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law (usually only for child custody cases.) If I am subpoenaed, I usually provide the requested information, whether or not the information is favorable to the undersigned. Should you subpoena Katherine Glassey as a factual witness or involve her in court-related processes, a non-refundable retainer fee of $1500 is required with a charge of $200 every additional hour I am involved in a case preparation, reports, phone calls, travel and witness time.

Contacting: I may be reached at 972-246-8472 and will be alerted of your voicemail. I do not interrupt sessions to respond to calls; therefore, I will return calls as soon as I am able.

Emergencies: You may encounter a personal emergency, which will require prompt attention. In this event, please contact me regarding the nature and urgency of the circumstances, and I will make every attempt to schedule you as soon as possible or to offer you other options. In you are experiencing a life-threatening emergency, please call 911 or go to the nearest hospital. Upon my death or incapacitation, your records will be stored with Ms. Kimberly Hatley, LPC, LMFT at Coppell Counseling Center, Inc. Records will be retained for 5 years past the date of our last appointment.

Confidentiality: Discussions between a therapist and client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include, but are not limited to, the following situations: reports of child abuse, abuse of the elderly or disabled, sexual exploitation, criminal prosecution, child custody cases, situations where the therapist has the duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose.

Uses and disclosures about personal healthcare information (PHI) will be made only with a client's (or authorized representative's) written authorization including: 1) most uses and disclosures of psychotherapy notes or communication between the therapist and client. Individuals will be notified if there is a breach of unsecured PHI. As a client, you have the right to restrict certain information to health plans where a client pays out-of-pocket.

Complaints: If you have any concerns about my services, I encourage you to discuss these with me at once. If you would like to make a formal complaint against a Licensed Professional Counselor you may contact:

Texas State Board of Examiners of Professional Counselors
Complaints Management and Investigative Section
P.O. Box 141369
Austin, TX 78714-1369
Email: lpc@dsjs.state.tx.us Telephone: 512-834-6658 Fax: 512-834-6789

By signing this consent form, you are giving your consent for me to share confidential information with all persons mandated by law. I have read and understood the above policies regarding counseling services with Katherine Glassey, M.A., LPC

NOTE: If you are consenting to treatment of a minor child, and if a court has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Katherine Glassey, M.A., LPC will not render services to your child until she h as received and reviewed a copy of the most recent applicable court order.

I understand and agree to the terms of this policy. I have discussed any questions that I have regarding this information with Katherine Glassey, M.A., LPC. My signature below indicates that I give my full and informed consent to receive counseling services.

_____ _____

Client Signature Date

_____

Client Printed Name

_____ _____

Signature of Parent/Guardian Date

_____

Parent/Guardian Printed Name

_____ _____

Therapist Signature Date

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Informed Consent for TeleMental Health Services

The following information is provided to clients who are seeking TeleMental health therapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

TeleMental Health Defined

TeleMental health means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

Limitations of TeleMental Health Therapy Services

While TeleMental health offers several advantages such as convenience and flexibility. It is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see various details such as facial expressions. Or, if audio quality is lacking, I might not hear differences in your tone of voice that I could easily pick up if you were in my office.

Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As the therapist, I will take every precaution to insure a technologically secure and environmentally private psychotherapy session. As the client, you are responsible for finding a private quiet location where the sessions may be conducted. Consider using a “do not disturb” sign/note on the door. The virtual sessions must be conducted on a wifi connection for the best connection and to minimize disruption.

In Case of Technology Failure

I understand that during a TeleMental health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, I will call you back on your number. Please make sure you have a phone with you, and I have that phone number. We may also reschedule if there are problems with connectivity.

Structure and Cost of Sessions

I offer face-to-face psychotherapy when appropriate and available. However, based on your ability to make in-person sessions and my availability, I may provide virtual psychotherapy if your treatment needs determine that TeleMental health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental health, or both. We will discuss what is best for you. Please remember that your insurance company may or may not cover therapy via phone or video. We are both responsible for understanding your mental health benefits. Please contact your insurance provider to verify coverage via TeleMental health. The structure and cost of TeleMental health sessions are exactly the same as face-to-face sessions. I will charge your credit card at the conclusion of each TeleMental health interaction.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Emergency Management Plan

Katherine Glassey, MA, LPC will see you in the event of a crisis. If I am unavailable I will provide the contact information of a colleague. If my colleague or I are unavailable in the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify a nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. These all must be completed to participate in TeleMental health services.

1. Hospital Name and Location:

_____

Hospital Telephone Number:_____

Emergency Contact Person:_____

Relationship _____ Telephone Number:_____

You may alternatively follow this plan:
1. Call Lifeline at (800) 273-8255 (National Crisis Line)
2. Call 911.
3. Go to the emergency room of your choice.

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Consent to Treatment
I voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Katherine Glassey, MA, LPC to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Katherine Glassey, MA, LPC at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____
Patient/Client Signature

_____
Parent, Guardian or Legal Representative Signature (if minor or needed otherwise)

_____
Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____
Katherine Glassey, MA, LPC Date

Katherine Glassey, M.A., LPC
Individual, Child, Adolescent and Family Counseling
Coppell Counseling Center • 413 West Bethel Road, Suite 202 • Coppell, TX 75019
(p) 972-246-8472 • counseling@katherineglassey.com

Good Faith Estimate

(Only to be completed for client's not using insurance for counseling services)

As of January 1, 2022, state-licensed or certified health care providers need to give a Good Faith Estimate of healthcare charges to every new and continuing client who is either uninsured or is not planning to submit a claim to their insurance for the healthcare services they seek.

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

General Billing Practices and Fee Schedule for Katherine Glassey, MA, LPC

My fee for a 50-minute psychotherapy session (Individual, Couples, or Telehealth) is $100. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs.

The below information will help you estimate your treatment costs.

When calculating or trying to estimate your expected cost over time you can multiple the above applicable number by the number of weeks you expect to be in therapy. Clients attending weekly therapy for one year can expect to attend, at most, 50 therapy sessions per year. Likewise, clients attending bi-weekly therapy can expect to attend at most, 25 sessions per year.

Please keep in mind the information in this document is NOT binding, meaning you, the client, can terminate psychotherapy services at any time. In no way does signing this form mean that you are committing to the number of sessions listed above.

If at any time you would like an updated cost estimate, based on a change in your treatment, please feel free to request this at any time.

By signing this document you are simply acknowledging that Katherine Glassey, MA, LPC has shared this form with you and disclosed an estimate for your services, should you chose to not utilize any insurance benefits.

Client Name: _____ **Date**: _____

Please select the ESTIMATED number of sessions you are planning on attending over the course of the year:

- ☐ I am planning on attending therapy sessions every other week, or approximately 25 sessions.
- ☐ I am planning on attending therapy sessions every week, or approximately 50 sessions.
- ☐ I am planning on attending therapy sessions monthly, or approximately 10 sessions.
- ☐ I have a different plan: _____

Our agreed upon fee for a 50-minute counseling session is: $_____

Based on the information above (session fee x meeting frequency), the total estimate for therapy services over the course of the next 12 months is: $_____

I understand the contents of this document and now have received adequate information to have an estimate about what it will cost me to attend therapy services in the year. I understand that this estimate may change if I change the frequency in which I attend therapy, and I understand that I can ask Katherine Glassey, MA, LPC for an updated estimate at any time.

Clinician Information for Katherine Glassey, MA, LPC
LPC License #: 68741

_____ _____

Client Signature Date

_____

Client Printed Name

_____ _____

Signature of Parent/Guardian Date

_____

Parent/Guardian Printed Name

_____ _____

Therapist Signature Date