Katherine Leath M.Ed, LPC

Personal Information

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Male ____ Female _____ Minor ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Address: _____

City, State, Zip: _____ Referred by: _____

Employer: _____ Occupation: _____

Referred by: Yellow Pages; Insurance Company; Other: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Where would you like us to leave reminder messages: Home ____; Work ____; Cell Phone ____; Email ____; None ____

If there is emergency at the office and we must cancel the appointment, where should we call: _____

In the event of an emergency with you, whom should we contact: Name: _____

Relationship: _____ Work # _____ Home # _____

Who is responsible for this account?

Name: _____ Relationship to Patient: _____

Birthdate: _____ Soc. Sec. # _____

Address: _____

City, State, Zip: _____

Employer: _____

Occupation: _____ Work # _____ Home # _____

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payors and/or other health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Katherine Leath the right to seek the services of a bill-collecting agency in efforts to collect fees I have not paid to him for services rendered and/or for cancelled or missed appointments.

_____ _____

Signature of patient or parent if minor Date

About Your Education:

Where did you attend public school? _____

Did you attend college? When, where? _____

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

About Your Relationships:

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

	Spouse's name	Year Begun	Year Ended	Married to this person	Children from this relationship & ages
1					
2					
3					
Please list all people who live with you:					

About Your Family:

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

About Your Health:

Who is your Doctor? _____ Last Visit: _____

Concerns? _____

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

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

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

About Your Concerns

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

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

_____

_____

_____

_____

_____

Please Read and Initial Each Statement:

_____I understand that Katherine Leath, M.Ed. is a Licensed Professional Counselor in the state of Texas

_____I understand that during the time we work together, we will usually meet weekly for approximately 45 minute sessions. Although our sessions may be psychologically deep, ours is a professional relationship rather than a social one.

_____I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

_____I understand that our contact will be limited to counselling sessions except in case of emergency.

_____I understand that Katherine Leath, M. Ed, LPC does not provide 24-hour crisis counselling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 911 or go to an emergency room.

_____I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.

_____I understand that at any time, I may initiate a discussion with Katherine Leath, M. Ed, LPC regarding possible positive or negative effects of entering or not entering into, continuing or discontinuing counseling, and that specific results are not guaranteed although benefits are expected.

_____I understand that Katherine Leath can perform some testing and will refer out for testing she is not authorized to administer in the state of Texas.

_____I understand that counseling is a personal exploration that may lead to major changes in your life perspectives and decisions. These changes could be temporarily distressing.

_____I understand that if I have a complaint I cannot resolve with Katherine Leath and I wish to file a formal complaint I may contact the Texas State Board of Examiners for Licensed Professional Counselors at (512) 834-6658.

_____I understand that I am responsible for all counseling service fees to Katherine Leath due at time services are rendered

_____I understand there is a returned check fee of $25.

_____I understand that if I do not give **at least 24 hours notice in canceling an appointment or fail to show for a scheduled appointment I will be charged the full fee of $100.00 before my next appointment can be scheduled.**

_____I understand that the rates for sessions are $100.00. These fees are for a play therapy session of 45 minutes and an individual session of 50 minutes.

_____I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, classroom observations, interactions with insurance providers, copying records, participating in legal depositions, phone calls over 5 minutes, etc. will be billed at the current hourly rate, $100.00, in 15 minute increments.

_____In the event of my permanent disability or death, my client files will be turned over to my records custodian, Steffanie Strawbridge, LCSW. She will make sure that you are appropriately referred to another counselor.

_____No form of communication outside of session is guaranteed to be private. Conversations can be overheard, texts can be read, emails can be sent to the wrong recipients, and electronic information can be hacked. By using any electronic method to send messages to me, I will assume you have made an informed decision to take the risk that

the message may be intercepted. Emails, text messages and phone calls are ideally for arranging or rescheduling appointments. I will not discuss your therapy or engage in counseling through these electronic means. If you send an email that is meant for discussion, I will not reply and we can address it in our next session.

_____I understand that Katherine Leath, M. Ed, LPC, **does not agree to serve as an expert witness, or provide testimonial services to you for court custody and/or divorce hearings.** Should you, your attorney, your spouse's attorney, or your ex-spouse's attorney subpoena Katherine Leath, M. Ed., LPC or your client file as a factual case witness or involve Katherine Leath, M. Ed, LPC, in court related proceedings, **I agree to pay $300 for every hour involved including but not limited to case preparation, travel, witness time, and any wait time related to court proceedings. I also agree to pay a $2,000 retainer fee to be applied toward these charges**. If a subpoena is issued to Katherine Leath, M. Ed, LPC, it will be turned over to our attorney and a bill will be rendered to you for immediate payment.

_____I understand that all of our communications are part of the clinical record, and therefore are property of Katherine Leath, M. Ed, LPC. Legally and ethically, Katherine Leath, M. Ed., LPC has to keep client records for 7 years after termination of counseling or 7 years after a minor child turns 18 years of age.

_____I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Katherine Leath, M. Ed, LPC to tell someone else in writing or verbally, b) Katherine Leath, M. Ed, LPC determines that the client poses a threat to them self or others, c) Katherine Leath, M. Ed, LPC is ordered by a court to disclose information, d) Katherine Leath, M. Ed, LPC suspects that child, elder, or disabled persons abuse has taken place, or e) disclosure of sexual contact with a mental health professional.

_____I understand that Katherine Leath, M. Ed., LPC is not a psychiatrist, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medication evaluation.

_____I understand that in the case where a referral is needed, Katherine Leath, M. Ed., LPC will provide some alternatives, including programs and/or people who may be able to assist me. I am responsible for contacting them.

_____I understand that Katherine Leath, M. Ed., LPC may set boundaries including forms of acceptable client interactions and communication including ceasing to provide services to the client for any reason including without limitation: Refusal of client to comply with treatment recommendations, issuance of subpoena for records or court room testimony, counselor is uncomfortable or feels threatened by client, or client's failure to timely pay fees in accordance with this agreement, subject to the professional responsibility requirements to which counselors are subject.

By your signature below, you are indicating that you have read and understood this document, and that any questions you had about this document were answered to your satisfaction, and that you were furnished a copy of this document:

_____

Client/Parent of Client Date Received and Read

_____

Counselor Date Received and Read

Mental Status Information

Have you ever attempted suicide or harmed yourself in any way? ☐Yes ☐No

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

Have you had thoughts of suicide or harming yourself in any way? ☐Yes ☐No

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

Agreement for Therapy

I, _____

Agree to receive therapeutic services provided by Katherine Leath, M.Ed, LPC. I have read, understood and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family. Furthermore, I understand that I am expected to be an active participant in this process. I acknowledge that I have received and understood the Notice of Privacy Practices for this office. My signature below means that I understand and agree with all of the points above.

_____

Client/Parent of Client Date Received and Read

Health Provider's Statement

I have inquired to insure that the patient/client understood the above description of the limits of confidentiality.

_____

Health Provider's Signature Date

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 of 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/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:

Your protected health information will be used, as needed, to obtain payment for 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 your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our office. In addition, we may call you 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 and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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/or guardian is client is a minor Date

Consent For Use and Disclosure of Health Informations: I hereby permit and release Katherine Leath, M.Ed, LPC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client Signature/or guardian is client is a minor Date

You have the right to 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 on your signing this consent.