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 payers 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 that I have not paid for services rendered and/or for cancelled or missed appointments.

Signature of patient or parent if minor _____ Date _____

About Your Child's Education:

Age: _____Grade: _____Nick Names: _____Failure or Held Back? _____

What do school personnel tell you about your child? _____

Grade	School	Average Grade	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

About Your Child's Family:

Relatives	Name	Age/Grade	Does child get along well with this person?	Occupation
Father				
Mother				
Brother(s)				
Sister (s)				
Step mother				
Step Sister (s)				
Step Brother (s)				
List all people who live in the home with this child:				

About Your Child's Routine

What kinds of physical exercise does your child get?_____

How much coffee, cola, tea, or other caffeine does your child consume each day _____

Is your child's eating restricted in any way? How? Why? _____

Bedtime: _____Wake-up Time: _____Hours of sleep on an average night: _____

Does your child have any problems getting enough sleep? _____(Please describe fully.) _____

About Your Child's Health

Who is your child's pediatrician? _____When was the last visit? _____

Any Concerns shared by the doctor?_____

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

Describe any allergies your child has: _____

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please _____

List all prior counselors/dates/reasons: _____

Anything else you are concerned about? _____

(These Questions are regarding older children)

Is this child in a gang? _____Has this child used drugs? _____. If so, describe which drugs, frequency, age at first use, and amounts _____

Has this child ever been pregnant or fathered a child? _____If yes, please tell what happened with each pregnancy:

About Your Child's Symptoms

Please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- ☐ Accident-prone
- ☐ Affectionate
- ☐ Aggressive
- ☐ Argues
- ☐ Assaults
- ☐ Bathroom language
- ☐ Bigoted
- ☐ Bossy to others
- ☐ Breaks rules
- ☐ Breaks the law
- ☐ Bullied by others
- ☐ Bullies others
- ☐ Cheats
- ☐ Clowns around
- ☐ Competition
- ☐ Complains
- ☐ Complains of feeling sick
- ☐ Compliant
- ☐ Concern for other
- ☐ Conflicts at school
- ☐ Conflicts at home
- ☐ Conflicts with friends
- ☐ Conflicts with police
- ☐ Cries easily
- ☐ Cruel to animals
- ☐ Dares others
- ☐ Dawdles
- ☐ Daydreams
- ☐ Defiant
- ☐ Dependent
- ☐ Destructive
- ☐ Developmental delays
- ☐ Difficulties w/ parent's partner
- ☐ Disobedient
- ☐ Disrupts family activities
- ☐ Distractible
- ☐ Dropping out of school
- ☐ Drug or alcohol use
- ☐ Drug sales
- ☐ Eating Issues
- ☐ Failure in school
- ☐ Fantasy life
- ☐ Fearful
- ☐ Feelings are easily hurt
- ☐ Fidgety
- ☐ Fighting
- ☐ Finger sucking
- ☐ Fire setting
- ☐ Friendly
- ☐ Hair chewing
- ☐ Head banging
- ☐ Hitting
- ☐ Hostile
- ☐ Hyperactive
- ☐ Hypochondriac
- ☐ Imaginary playmates
- ☐ Immature
- ☐ Inappropriate sexual behaviors
- ☐ Inattentive
- ☐ Independent
- ☐ Inflicts pain on others
- ☐ Insults others
- ☐ Interrupts
- ☐ Intimidated by others
- ☐ Intimidates others
- ☐ Intolerant
- ☐ Irritability
- ☐ Isolates
- ☐ Lacks organization
- ☐ Lacks respect for authority
- ☐ Learning disability
- ☐ Legal difficulties
- ☐ Lethargic
- ☐ Likes to be alone
- ☐ Loitering
- ☐ Loss of friends
- ☐ Low frustration tolerance
- ☐ Lying
- ☐ Manipulates
- ☐ Masturbation
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Name calling
- ☐ Need for high degree of supervision
- ☐ Negativism
- ☐ Nervous
- ☐ New school
- ☐ Nightmares
- ☐ Noisy
- ☐ Noncompliant
- ☐ Obedient
- ☐ Obesity
- ☐ Only younger playmates
- ☐ Oppositional
- ☐ Outgoing
- ☐ Out-of-seat behaviors
- ☐ Overactive
- ☐ Picks on others
- ☐ Poor concentration
- ☐ Pouts
- ☐ Prejudiced
- ☐ Procrastinates
- ☐ Provokes others
- ☐ Rages
- ☐ Recent move
- ☐ Refuses
- ☐ Relationships with friends
- ☐ Relationships with siblings
- ☐ Relationships with teachers
- ☐ Resists
- ☐ Responsible
- ☐ Restless
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad
- ☐ School avoiding
- ☐ Self-harming behaviors
- ☐ Sexual preoccupation
- ☐ Sexually active
- ☐ Shy
- ☐ Slow-moving
- ☐ Slow-responding
- ☐ Smart-alecky
- ☐ Smoking
- ☐ Social
- ☐ Speech difficulties
- ☐ Stealing
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing
- ☐ Talks back
- ☐ Talks out
- ☐ Teased
- ☐ Teases others
- ☐ Temper tantrums
- ☐ Threatens
- ☐ Thumb sucking
- ☐ Tics-movements or noises
- ☐ Timid
- ☐ Truancy
- ☐ Uncooperative
- ☐ Uncoordinated
- ☐ Under-active
- ☐ Unhappy
- ☐ Unprepared
- ☐ Vandalism
- ☐ Violent
- ☐ Wastes time
- ☐ Wetting/soiling of bed/clothes
- ☐ Withdraws
- ☐ Work problems
- ☐ Yells
- ☐ Any other characteristics:

_____
_____
_____
_____

- ☐ Other Concerns:

_____
_____
_____
_____

Please Read and Initial the Informed Consent After Each Statement:

_____I understand that Katherine Leath, M.Ed. is a Licensed Professional Counselor(#67708) 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 and agree that I am responsible for all counseling service fees to Katherine Leath due at time services are rendered

_____I understand and agree 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 and agree 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 $200 for every hour involved, with a 4-hour minimum charge, including but not limited to case preparation, travel, witness time, and any wait time related to court proceedings.** Payment is due and **non-refundable** 72 business hours in advance. And additional time spent on the day of the court/deposition appearance will be billed within 24 hours and is expected to be paid in full within 48 hours of the bill being sent. 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 and agree 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.

_____I understand and agree that Katherine Leath, M.Ed, LPC has the right to suspend services if an unpaid balance exists on your account.

_____I understand that Katherine Leath, M.Ed, LPC does not accept third party insurance reimbursement and your insurance company would consider me an out-of-network provider. If you are not the responsible party, then the responsible party must provide a retainer or credit card on file.

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

Has your child ever attempted suicide or harmed yourself in any way? ☐Yes ☐No

Is your child currently thinking about suicide or harming yourself in any way? ☐Yes ☐No

Has your child had thoughts of suicide or harming yourself in any way? ☐Yes ☐No

Are your child's thoughts about harming anyone else in any way? ☐Yes ☐No

Agreement for Therapy with a Minor

I, _____, the parent/legal guardian of the minor, _____,

- Give Katherine Leath, M.Ed, LPC, full and unconditional authority to proceed with a clinical evaluation and treatment as her judgement indicates.
- I have legal power to consent to psychological and mental healthy assessment and treatment of said minor child(ren).
- It is clearly understood that Katherine Leath, M.Ed, LPC is herby fully released from and claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that her duties are performed with standard care and responsibility to the best of her professional ability.
- I have read, understood, and signed the informed consent related to my child's therapist and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his or her family.

- In cases of separation or divorce: I have provided legal documentation (divorce decree or current court orders) regarding conservatorship and my legal right to consent to treatment for my child.
- Furthermore, I understand that I am expected to participate in this process by meeting with the therapist at least once per month while my child is in therapy.

My signature below means that I understand and agree with all of the points above.

Signature of parent/guardian Date

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