INTAKE FORM

DATE: _____CAUSE NO: _____

Child(ren)'s Names and DOB:

_____ _____ _____

_____ _____ _____

SERVICE REQUESTED (Please Circle):

Collaborative Law Cooperative Parenting Co-parenting Coaching Mediation
Parenting Coordination Parenting Facilitation Reunification Therapy
Counseling

INTAKE INFORMATION (Please complete fully. List other family members or parties on a separate intake form or cross out where applicable):

Relationship to the child: _____

Name: _____DOB: _____

Street:_____ City_____ State: _____ Zip: _____

Phone: (H)_____ (Cell) _____

Email: _____

Your Attorney's Information:

Name: _____ Legal Assistant: _____

Street: _____ City _____ State: ____ Zip: _____

Phone: (W) _____ (Cell): _____

(E-mail) _____

Your Co-parents Information:

Name: _____

Name: _____

Street:_____ City:_____ State: _____ Zip: _____

Phone: (H)_____ (W) _____ (Cell.) _____

E-mail address: _____

Your Co-parent's Attorney's Information:

Name: _____ Legal Assistant: _____

Street: _____ City _____ State: ____ Zip: _____

Phone: (W) _____

(E-mail) _____

Ad Litem or Amicus Attorney for child: (If applicable)

Name: _____ Legal Assistant: _____

Street: _____ City _____ State: ____ Zip: _____

Phone: (W) _____

(E-mail) _____

Credit Card to keep on file:

Credit Card #_____

Expiration Date:_____

Security Code:_____

Zip code associated with credit card:_____

- Your signature above indicates that you have read and understood the credit/debit card and delinquent account policy. You are authorizing Cindy Chilcote, LCSW, PLLC to charge the above credit card for ongoing payment toward your balance. You are aware that your information will be saved on file for a future transaction on your account.

Pre-Authorization of Care and Agreement for Services

Introduction:

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

Information About Your Therapist: Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

Cindy Chilcote is a Licensed Clinical Social Worker. The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint.

Texas Behavioral Health Executive Council
333 Guadalupe St., Ste. 3-900
Austin, Texas 78701
Tel. (512) 305-7700
1-800-821-3205 24-hour, toll-free complaint system
www.bhec.texas.gov

Therapist's Name, License Type and License Number:

Cynthia Chilcote, LCSW State of Texas License Number: 55990

Fees: The fee for service is $175 per 50-minute therapy session. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance.

Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

If there is a need for telephone contact, with you or a third party, other than for scheduling purposes, you understand that you are responsible for payment of the agreed-upon fee (on a pro-rata basis) for any calls lasting longer than 10 minutes.

If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider any other options that may be available to you at that time.

Delinquent Accounts. You understand that you are responsible for all charges incurred and that services must be paid in full at each visit unless other arrangements have been made in advance.

Good Faith Estimate: It is my goal to always be transparent with you about fees and financial obligations. Each person or family's situation is different, so there is no way to adequately predict how many sessions are going to be required for your child, yourself, or your family. On average, 10-15 sessions are needed. (10-15 sessions X $175/session=_____). Please note that attending therapy sessions are a choice unless court-ordered.

Patient Litigation and Litigation Fees: If needed I will participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of $175 per hour. If I am required to cancel my other appointments for the day, a fee of $1,500 will be assessed to whatever party is subpoenaing me.

Appointment Scheduling and Cancellation Policies: Sessions are typically scheduled to occur one time per week or every other week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you. If an appointment is missed, or canceled with less than 24 hours notice, you (not your insurance company) may be charged the full fee for that missed session. Exceptions may be made if you are sick or have an unavoidable emergency.

Appointments are 50 minutes in length. The initial session focuses on the history, answering questions, and preliminary treatment planning. In treating children or families, this session is reserved for the primary caregivers only. I like to meet with both parents individually prior to meeting the child for the first time. Teletherapy sessions are available to parents.

Risks and Benefits of Therapy: Psychotherapy is a process in which we will discuss a myriad of issues, events, experiences, and memories for the purpose of creating positive change so that you can experience your life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties you may be experiencing. Psychotherapy is a joint effort between us. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, including active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. There may be times in which I will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including

changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility. During the therapeutic process, many people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. You should discuss with me any concerns you have regarding your progress in therapy. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Limitations of the TeleMental Health Therapy Services:

TeleMental Health offers several advantages such as convenience and flexibility. It is an alternative therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption of service (phone gets cut off or video drops). This can be frustrating and interrupt the session. As your therapist, I will make every effort to ensure a technologically secure and environmentally private psychotherapy session. As the client, you are responsible for finding a private location where the session will be conducted. If children are doing a TeleMental health session, they are to be given privacy. Children are to not be recorded or viewed on the camera.

Discussion of Treatment Plan: It is my intention to provide services that will assist you in reaching your goals. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various treatment approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, biofeedback, neurofeedback, and/or psycho-educational techniques.

I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination of Therapy: The length of your treatment and the timing of the eventual termination of your treatment depends on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

Professional Consultation: Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in a clinical, ethical, and legal consultations with

appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

Collaboration with Other Professionals: In order to provide quality services, I often need to collaborate with other professionals, such as your attorney, physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; if you are not comfortable signing a release of information, you do not have to.

Records and Record Keeping: I may take notes during the session and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under Texas law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating healthcare provider. I typically maintain records for ten years following the termination of therapy. After ten years, your records will be destroyed in a manner that preserves your confidentiality.

Confidentiality: The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving a suspected child, elder or dependent adult abuse; cases in which I am court-ordered to testify or produce records; or as outlined in the "Notice of Privacy Practices" (copies available).

RECORDING OF SESSIONS:

I UNDERSTAND THAT THERE WILL BE NO RECORDING OF ANY SESSIONS AND THAT ALL INFORMATION DISCLOSED WITHIN SESSIONS AND THE WRITTEN RECORDS PERTAINING TO THOSE SESSIONS ARE CONFIDENTIAL AND MY NOT BE REVEALED TO ANYONE WITHOUT MY WRITTEN PERMISSION, EXCEPT WHERE DISCLOSURE IS REQUIRED BY LAW. I WILL NOT PLACE A RECORDING DEVICE ON MY CHILD OR IN MY CHILD'S POSSESSION DURING THE CHILD'S SESSIONS. IF A CHILD'S SESSION IS FOUND TO BE RECORDED, THE JUDGE AND ATTORNEYS WILL BE ALERTED THAT THERE HAS BEEN A VIOLATION TO THE CHILD'S PRIVACY. Please Initial Here: _____

Psychotherapist-Patient Privilege: The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. You should be aware that you might be waiving the psychotherapist-patient privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding. You should address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

Therapist Availability / Emergencies: You may leave a message for me at any time on my voicemail at 832-600-2585. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday). Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, go to the nearest emergency room. Feel free to text me if there is a true emergency.

Acknowledgment

By signing below, Patient(s) acknowledge that they have reviewed and fully understand the terms and conditions of this Agreement. Patient(s) have discussed such terms and conditions with the therapist and have had any questions with regard to its terms and conditions answered to Patient(s)' satisfaction. Patient(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist.

_____ _____

Signature of Patient (or authorized representative) Date

PRIVACY (CONFIDENTIALITY) POLICY

State and federal laws protect the confidential nature of the therapist-client relationship. Clinical information will not be released to anyone without prior written consent to do so by the client (or the guardian-parent of a minor). However, there are some exceptions where information may be released without client consent. These include: A therapist must take appropriate action when there is a danger to the client or to another individual at the client's hands. In general, this means that the therapist may involve others to protect the client if he or she is suicidal or is unable to provide self-care at a level necessary for basic survival. Others may also be involved to prevent harm to another person. State law mandates that suspected neglect or abuse of a child, of an elderly individual, or of a disabled individual must be reported. When ordered by a court to do so, a therapist may testify or release client records. However, no release of information or testimony is given in response to a subpoena without the client or client guardian's written authorization unless required by law to do so. Consultation with other health care professionals may be necessary at some point in time. Where possible, identification of clients is withheld. However, there are times when exchange of information is necessary. An example of this type of exchange would be when the therapist is out of town or on vacation and another therapist is providing coverage for that therapist. Case material is often used for training, for research, and for other academic endeavors but client identification is always removed. Any other release of information must come with the above listed written approval. I understand that this agreement is valid for the duration of time that I am participating in services with Cindy Chilcote, LCSW, PLLC. By signing below, I acknowledge that I have received a copy of the Pre-Authorization for Health Care and the Privacy (Confidentiality) Policy, and I understand and agree to the entire contents of those documents. I acknowledge that I have had an opportunity to have answered any questions, comments or concerns that I might have had prior to signing this consent and participating in services. I am aware that I can stop counseling at any time as long as not court-ordered. Cindy Chilcote, LCSW, PLLC reserves the right to amend the Pre Authorization for Health Care and the Privacy (Confidentiality) Policy and changes will be available at the office of Cindy Chilcote, LCSW, PLLC and on the www.CindyChilcote.com. I can request a copy of changes at any time at no charge. Any changes that Cindy Chilcote, LCSW, PLLC makes are effective immediately unless otherwise indicated.

CLIENT SIGNATURE (18 and older):_____ Date:_____
SIGNATURE OF PARENT _____(for a child age 17 or younger) Date: _____

Pre-authorization for Care and Consent to Treatment of Minors

I affirm that I am the legal guardian of _____ and hereby grant permission for my child to participate in counseling/related services with this therapist.

If there are court papers regarding custody, the most recent temporary and/or final orders need to be provided to Cindy Chilcote, LCSW, PLLC prior to any child being seen.

Confidentiality with Minors

I understand that any information I or my child provide to Cindy Chilcote, LCSW, PLLC is confidential and generally will not be released to others without my written consent. However, I understand that professional ethical obligations and state and/or federal law might require Cindy Chilcote, LCSW, PLLCWto disclose confidential information without my consent in certain circumstances. I understand Cindy Chilcote, LCSW may be required to disclose confidential information, without my consent, in one or more of the following situations:

In the event that the therapy session reveals any information concerning the abuse of a child, elder or disabled person, Cindy Chilcote, LCSW, PLLC is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this fact.

If the course of therapy reveals any intent my child may have to harm either himself/herself or others, I acknowledge Cindy Chilcote, LCSW, PLLC has the legal and moral duty to prevent my child from bringing this harm about. I specifically give my irrevocable permission to warn those parties she feels may be harmed. If my child reveals an intent to harm himself/herself, Cindy Chilcote, LCSW, PLLC has my permission, also irrevocable, to prevent my child from accomplishing that intent.

I hereby consent to the treatment of my child(ren) per the terms outlined in the above pages of this document:

Name _____ Birthdate _____

Name _____ Birthdate _____

Parent / Guardian Name (please print) Parent/Guardian Signature:

_____ _____

Date: _____