

Cassie Reid

counseling



112 State Street, Suite 227
Southlake, Texas 76092
info@cassiereid.com
(817) 756-1440

Therapist: Jessica LeFlore, M.A., LPC

Today's Date

Client Name

Parent/Guardian (if client under 18)

Parent/Guardian (if client under 18)

Client Age	Date of Birth	Male	Female
Single	Married	Divorced	Widowed

Mailing Address

Home Phone

Cell Phone

Other Phone

Leave Messages at:

Home Phone	Cell Phone	Other Phone
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If we must cancel your appointment due to an emergency at our office, call your:

Home Phone	Cell Phone	Other Phone
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Client Employer

Spouse Employer

Parent/Guardian Employer

Parent/Guardian Employer

How did you hear about Cassie Reid Counseling?

Gateway Church Who?

Friend Who?

Facebook Twitter Website Psychology Today

Google Bing Yahoo Other

Why are you seeking counseling?

Approximately how long have you had the current problem?

Do you have a mental health diagnosis? If so, which one?

Are you under the care of a mental health professional? If so, whom?

Have you been prescribed any drugs by a psychiatrist or physician?

Yes No

List all medications or drugs you have taken in the past year

About Your Family

Relative	Name	Living? Yes/No	Age	Will they be attending therapy?	Other information
Father					
Mother					
Sister(s)					
Brother(s)					
Other significant persons					

Professional Disclosure Statement and Informed Consent

INITIAL EACH ITEM:

I understand that Jessica LeFlore is a Licensed Professional Counselor in the state of Texas

I understand that Jessica LeFlore does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.

I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with Jessica LeFlore's services as a therapist, I have a right to let her know. If I do not feel that Jessica LeFlore may resolve my complaint, I may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

I understand that the rate for individual counseling sessions is \$100.00 for a 50-minute session.

I understand that all fees for counseling are due at the time services are rendered.

I understand that I am responsible for any appointments that are not canceled at least 24 business hours prior to my appointment time. Business hours are defined as Monday through Friday 9:00am to 7:00pm.

I understand that if I do not cancel my appointment 24 business hours prior to my appointment time, the fee for calling to cancel on the day of my appointment is \$100.00

I understand that by not showing up for a scheduled appointment will result in my being charged \$100.00 for the full missed session.

I understand that if I have a phone conversation 15 minutes or longer with Ms. LeFlore, it will be considered a counseling session with billing immediately beginning for one half hour and every quarter hour as necessary.

I understand that phone counseling sessions or office counseling sessions on weekends are billed at \$150.00 per hour.

I understand that if I arrive after the scheduled appointment time, the session will still end at the appointed time.

Professional Disclosure Statement and Informed Consent (cont.)

INITIAL EACH ITEM

I understand that if I arrive after the scheduled appointment time, the session will still end at the appointed time.

I understand that if Jessica LeFlore is to testify in court the fee for this service is \$150.00 per hour with a 4-hour minimum within 40-mile radius and an 8-hour minimum for travel beyond a 40-mile radius with travel time billed at the same rate and preparation time billed at the same rate. Mileage charges will be added at the standard IRS rate. Overnight lodging if necessary will be billed as well.

I understand that if Cassandra Reid is to perform an intervention, the fee is \$150.00 per hour with a 4-hour minimum within a 40-mile radius and an 8-hour minimum beyond a 40-mile radius with travel time billed at the same rate and preparation time billed at the same rate. Mileage charges will be added at the standard IRS rate.

I understand that my records and all of our communications become part of the clinical record. Records are the property of Cassie Reid Counseling LLC. All client records are disposed of seven (7) years after the client has stopped receiving services.

I understand that if required, time spent by Jessica LeFlore sending emails, text messages and phone conversations when exceeding 15 minutes will be considered a billable quarter hour with payment due during the next scheduled in office appointment

I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- You are a danger to yourself or someone else
- In situations of suspected child, spouse, elder or other physical abuse, it is the duty of the mental health provider to notify medical, legal, or other authorities
- You disclose sexual contact with another mental health professional
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court
- Cassandra Reid is ordered by a court to disclose information
- You direct Cassandra Reid in writing to release your records
- Cassandra Reid is otherwise required by law to disclose information

Statement of Understanding

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge

Client Signature

Date

HIPAA Notice of Privacy Practices

This Health Insurance Portability and Accountability Act (HIPAA) 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.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPAA Notice of Privacy Practices for Cassie Reid Counseling LLC:

Client Signature (parent or guardian if minor patient)

Date

HIPAA Authorization Form

This form serves to authorize the release of information discussed during sessions if this information needs to be released to an outside party such as a school counselor, psychiatrist, or medical doctor. This form is not required for treatment but is the only form that will authorize Cassandra Reid to speak with any individuals outside the therapy room.

Client Name (please type or print clearly)

Date of Birth

I _____ hereby authorize Jessica LeFlore M.A., LPC to disclose to and/or obtain from _____ (name of individual to receive or provide information) the following types of information:

(Client should check all that apply)

Assessment/Diagnosis

Continuing Care Plan

Information

Psychological Evaluation

Educational Records

Treatment Update

Special Education Records

Treatment Plan or Summary

Counseling Notes

Other

Psychosocial Assessment

Revocation

INITIAL EACH ITEM

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Jessica LeFlore M.A., LPC at the following address:

**112 State Street, Suite 227
Southlake, TX 76092**

I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Credit Card Authorization Form

I _____ Authorize **Cassie Reid Counseling LLC** to charge my credit card
(CLIENT NAME)

For services rendered, missed session fee (\$100) or late cancellation fee (\$100)

CREDIT CARD TYPE: Visa MasterCard AMEX Discover

CREDIT CARD #:

CARD CV2 #:

EXPIRATION DATE:

BILLING ADDRESS:

Number

Street

City

State

Zip

NAME ON CARD

(As it appears on card)

SIGNATURE

DATE

DO NOT WRITE BELOW. COMPANY USE ONLY.

NOTES:
