Thank you for choosing CCA! We look forward to working with you. Please download, print and complete this packet in its entirety filling out as much detail as possible and bring it to your appointment as a new client, or if you are returning after 6 months of not being seen.

Please arrive 10 minutes early so that we can check the information and make a copy of your insurance card when staff are available. If you wish to verify that we are an in-network provider and your co-pay for mental health services, please call the number on the back of your insurance card.

Allen:
1506 N. Greenville Ave, Suite 200
(to the left of State Farm) in the Alliance Center offices in Allen, TX across from St. Jude Catholic church.

COMMUNITY **C**OUNSELING **A**SSOCIATES
1506 N. Greenville Ave, Suite 200
Allen, Texas 75002
214-509-6888

Code _____
Begin Time _____
End Time _____
Next Appt _____
Pmt _____

CLIENT INFORMATION

Client Name _____ Date _____

Address _____ City _____ Zip Code _____

Phone #'s: HM _____ WK _____ Mbl _____ ☐message OK?

E-Mail Address _____ # of Children _____

Preferred Communication Method: _____ ☐message OK?

_____ (initials) I do NOT wish to receive information regarding upcoming counseling promotions and presentations.

Marital Status _____ Age _____ Birthday ____/____/____

Employment _____ Driver's License # _____

Emergency Notification _____
Name Relationship Phone

If client is a minor, please provide other parent's contact information:

_____
Name Relationship Phone E-Mail

Person Responsible for Payment _____

Phone Number: _____ Address (if different): _____

Referred by: google psych today ad church friend Other: _____

May we thank them? ____ yes ____ no

I hereby give the office Community Counseling Associates and their staff permission to file any claims and exchange any PHI (protected health information) necessary to receive payment for services performed. I understand that balances unpaid after 60 days will be my responsibility.

_____ _____
Signature Date

_____ _____
Signature Date

The information on the following intake form is crucially important in making the correct decisions in the direction of treatment. Please answer the following questions as completely as possible placing an N/A in those that do not pertain to your life situation.

COMMUNITY **C**OUNSELING **A**SSOCIATES
1506 N. Greenville Ave, Suite 200, Allen, TX 75002
214-509-6888

CONSENT FOR THIRD PARTY BILLING

If you choose to pay for therapy using a third-party payer such as a community agency or insurance company, I will typically submit authorization and claims forms directly to them. Third party payers typically do not cover fees for missed appointments, telephone consultations and certain other kinds of services.

Please carefully review with your payer all information about amount and type of services they cover. If you have questions, please contact your payer. If you remain unclear about what is being provided, I will be glad to contact the payer and attempt to clarify the situation. It is particularly important to understand that third party payers may authorize payment for a specific number of sessions only or may require that I request their approval of additional sessions after an initial allocation. Third party payers may make their own decisions, independent of my recommendation, about how much or what kinds of treatment they will pay for or believe is necessary.

Third party payers frequently require some information about your case when they agree to pay for treatment. Information required depends on the payer. Some examples of required information may include treatment attendance, or treatment information such as description of presenting problems, diagnosis, treatment type or plan, progress or treatment summary. You are welcome to discuss what is disclosed to payers with me at any time. **Although community agencies or insurance companies are typically required to keep such information confidential, I have no control over what they do with this information once it is in their files.**

By signing below, you agree to release all information necessary to the payer in order for me to obtain reimbursement for services, and you authorize direct payment to me by the payer. It is the client's responsibility to obtain authorization from any third-party payer, prior to the first appointment. Furthermore, the client is responsible for payment for all services rendered and charges incurred that are not covered by a third-party payer.

IF YOU WISH TO HAVE A THIRD PARTY BILLED PLEASE COMPLETE AND SIGN THE FOLLOWING:

Client Name and Date of Birth: _____

Parent/Guardian Name: _____

Signature: _____ Date: _____

Insurance Company or other 3rd Party Payer: _____

Insurance Group & ID# _____

Name of Insured Person: _____ Date of Birth: _____

Address of Insured Person: _____

Employer of Insured Person: _____

_____ _____
Client Signature Date

COMMUNITY **C**OUNSELING **A**SSOCIATES
1506 N. Greenville Ave, Suite 200, Allen, TX 75002
214-509-6888

CLIENT INTAKE QUESTIONNAIRE

What is your chief concern at this time? _____

_____

_____

What if any stressful life events have recently occurred? _____

_____

_____

Please check any current symptoms you are experiencing.

____ Decreased Energy	____ Panic Attacks	____ Intrusive/Negative Thoughts
____ Guilt	____ Excessive Worry	____ Concentration Problems
____ Sleep problems	____ Anxiousness	____ Obsessions/Compulsions
____ Hopelessness	____ Worthlessness	____ Relational Difficulties/Conflicts
____ Eating Problems	____ Impulsivity	____ Hyperactivity
____ Tearfulness	____ Irritability	____ Inappropriate anger
____ Mania	____ Delusions/Hallucinations	____ Self Injurious Behavior
____ Dissociative States	____ Increased Alcohol Use	____ Use of Illegal Substances
____ Thoughts of Death/Suicide	Other Symptoms _____	

When would you estimate that these symptoms began? _____

_____

What has been the course of your symptoms? (i.e. getting better, worse, or staying the same) _____

Have you experienced similar symptoms before? When? _____

_____

What have you tried that has made the symptoms better/worse? _____

_____

What (if any) psychotropic medications are you taking or have you tried? _____

_____

What (if any) medications are you currently taking (please include vitamins, supplements, and OTC)? _____

_____

_____

Date of last physical checkup? _____ Recent hospitalization? _____

Have you consulted other health professionals concerning your symptoms? List names and dates of counseling as well as problems addressed: _____

_____

Do you smoke? Y N Do you consume alcohol? Y N How many drinks per week? _____

Have you ever used (or are you currently using) any mood-altering substances? If so, please share when and for how long. (Substance use can create or influence depression/anxiety) _____

_____

Do you have a supportive and/or spiritual community? Explain _____

Briefly describe your relationships in your family of origin (close, distant, conflicted): _____

Briefly discuss any mental health or addiction issues that have occurred in your family dating back to grandparents: _____

Briefly describe your current significant relationships (friends and/or significant others): _____

Have you ever been the victim of abuse or experienced a traumatic event (child abuse, physical, verbal, sexual, rape, crime victim, bullying), or any significant event that impacted way you view yourself or your world? Explain _

Have you ever been married before or lived with someone for more than a year? Explain _____

Please share any other information you want me to know before we begin. _____

THERAPIST NOTES: _____

Patient seen with: ____ Mother ____ Father ____ Spouse ____ Other _____

Diagnostic Impressions: _____

Initial Treatment Plan: _____

Therapist Signature _____ Next Appointment _____

COMMUNITY **C**OUNSELING **A**SSOCIATES

1506 N. Greenville Ave, Suite 200, Allen, TX 75002
214-509-6888

INFORMED CONSENT

WHAT IS INVOLVED IN THE COUNSELING PROCESS?
Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. It requires a very active effort on the part of both the client and therapist. In order to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy has shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. Each individual's progress varies.

Our first session will involve an evaluation of your needs. By the end of the evaluation, your counselor will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with him/her. If you have questions about procedures, they should be discussed – no concern is too small if it affects the counseling relationship. If at any time you feel that the issues discussed have not been resolved to your satisfaction, please feel free to contact our center director or ask for a referral. If you decide to proceed with counseling, usually a **session lasts 45 minutes** in duration. Some sessions may be longer or shorter depending on your specific needs and treatment goals**.**

IS WHAT WE DISCUSS CONFIDENTIAL?
In general, the confidentiality of all communications between a client and a therapist is protected, and a counselor can only release information about what occurs during session to others with written permission. However, there are a number of exceptions including some legal proceedings. If a staff member believes that a client presents a **danger to him/herself or to someone else**, he or she is required to take protective actions. If a **child, an elderly person, or a disabled person is suspected of being abused**, a report must be filed with the appropriate state agency. Should such a situation occur, every effort will occur to fully discuss the concerns before taking action**. If interactions reveal that the client is a danger to themselves or others, their emergency contact will be notified or the local authorities.**

Understand that confidentiality is not the same as statutory privilege. If a legal subpoena is issued by the court or if you've given permission for exchange of information for insurance purposes, details regarding sessions may be disclosed. It is the center's policy to make every effort to contact you first should this occur. Please refer to the disclaimers on our Release of Confidential Information form.

To ensure you receive the excellent ethical care, generic case situations are staffed during private meetings and/or supervision. In these consultations, every effort is made to avoid revealing identifying information. The consultants are, of course, also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together. ***All associates and counseling students are involved in weekly supervision sessions where your identity will remain obscured, but your case will be discussed in detail***. Michelle Nietert, LPC Supervisor has access to all information regarding cases involving associates and counseling students at all times.

ADDITIONAL EXCEPTIONS
*******Please note that any individual attending group, joint marriage sessions and/or any family sessions has access completely to the records of that session. *******

- **MARRIAGE COUNSELING: If you are involved in marital counseling, confidentiality does not include your spouse and is left up to your counselor's discretion.** This will be explained further in your initial session.
- **PARENTS OF ADOLESCENTS:** ***If the client is a child or adolescent and is engaging in reckless behavior or persistent substance use, a need to discuss these activities with their parent will be discussed. The minor will then be given the opportunity to inform their parent/guardian during the counseling session of behaviors that are deemed by the counselor to be a harm to self.*** Please understand that we will not betray confidences of parental defiance or rebellion that are not life threatening. We will make every effort to encourage the minor to be forthright with their guardians as transparency is a

recognized dynamic of a healthy relationship. If a parent feels betrayed by our keeping of confidentiality, we encourage the family to schedule a family session to discuss this matter.

- **PARENT CONSULTATIONS**: Also, in counseling involving a minor child as the identified patient, the rights of confidentiality extend to them only. If you share information during a parent consultation that would impact their treatment or if the child is present, realize that either parent has access to the child's records and anything said by the other parent would not be considered confidential during a family session or parent consultation since they are not a counseling patient.
- **LEGAL ISSUES:** If at any time you involve any staff member or CCA as a company in legal proceedings including but not limited to requesting files for an attorney, having a subpoena issued by an attorney or court, requesting a staff member give a deposition, or verbally or in writing threatening to name a staff member or the organization in a lawsuit, we will disclose general case information to our attorney in order to follow best legal and ethical practices when addressing these issues.
  By initialing here, I am recognizing and agreeing to the exceptions to confidentiality listed on the previous page which could pertain to records requests made at a later date.

Clients' Initials _____ _____

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. The laws governing these issues are quite complex, and your counselor is not an attorney. Should you need specific advice, formal legal consultation is strongly recommended.

****Electronic Communication****:**
It is against HIPAA standards for us to contact you electronically using text or email that is not encrypted. ***If you so choose to use this means of communication, your counselor will not reveal or respond in any manner regarding counseling PHI (protected health information). Please make sure you keep records of your appointment schedule – last minute contacts to verify date and time that result in your not keeping an appointment will result in a cancellation fee. Occasionally, we realize urgent matters arise and brief message sent by text or email regarding a scheduling issue may occur. Please understand that information exchanged this way is NOT protected. If you wish for your counselor to respond in an urgent situation, please initial here. Also, if you counselor does not respond, you will need to follow up with a phone call and leave a message. It is your responsibility to confirm their receipt of any information sent my text or email.***

Clients' Initials_____ _____

CAN I SEE MY RECORDS?
Both law and the standards of my profession require that appropriate treatment records are kept. You are entitled to receive a copy of the records. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, it is recommended that you review them in your counselor's presence so that we can discuss the contents. Most often a summary is supplied because handwriting and notes are for the counselor's use in treatment and difficult to understand clearly. Clients will be charged $100 an hour for any preparation time required to comply with an information request including a minimum fee of $50 and must give two weeks' notice to allow for these records to be prepared. **If for any reason your counselor would become unavailable due to illness, injury, or death, please contact Michelle Nietert, LPC-S, at 972-979-9720. If she is not available, please contact her assistant at 972-755-1888.** She will become custodian of all files that have not been destroyed. Files are shredded six years after the date of our final session or in compliance with State Board and HIPAA guidelines.

HOW DO I CONTACT MY COUNSELOR?
Our main number **is 214-509-6888**. Your counselor will provide a business card with their extension and it is also listed on the website: www.communitycounselingassociates.com. Every effort will be made to return your call by the end of the next business day with the exception of weekends and holidays and otherwise noted on your counselor's outgoing message. **In emergencies, 911 or an emergency room should be utilized. You can leave me a message after contacting 911, your physician, the emergency room of your choice, or a licensed mental health facility.** If you do not receive an expedient response, please call our main number if you should need further assistance.

GIFTS
Please understand due to ethical standards set forth by the state of Texas and professional counselor associations, it is the center's policy not to receive gifts valued at above $50.00.

COMMUNITY **C**OUNSELING **A**SSOCIATES

1506 N. Greenville Ave, Suite 200, Allen, TX 75002
214-509-6888

PAYMENT POLICY

FEES: My standard fee is $_____ for an initial session, $_____ for a 45-minute session and $_____ for a twenty-minute session. (The actual cost to you may vary due to insurance and co-pays or a sliding scale agreement. If the client is using an EAP, the client will not be charged as long as their sessions are covered by the EAP.) If a licensed therapist is filing out of network insurance on behalf of the client, clients are responsible for the agreed upon rate for all sessions at the time the session occurs and they are also responsible to notify the therapist when the deductible has been met and their fee would be reduced. If the client overpays, a credit or refund would be issued at their request. **If a client has a change in insurance, it is their responsibility to notify their therapist and provide a copy of their new insurance card.** If this change results in unpaid sessions, the client will be financially responsible at the therapist's usual and customary rate listed above or a rate negotiated between them and the client when the discovery occurs. **If an unpaid claim exists for more than 60 days, it becomes the client's responsibility in full and we will provide a receipt for them to see reimbursement from the insurance company.** Parent consultations may or may not be covered by managed care. The parent who initiates the consultation is financially responsible for payment at the time of service.

It is our staff's practice to charge $125 or the therapist's highest rate on our sliding scale on a prorated basis (per quarter hour) for other professional services you may require, such as report writing, telephone conversations which last longer than 5 minutes, preparation of records or treatment summaries, or the time required to perform any other service which you may request. **A minimum fee of $25 is charge for copies of records or reports and minimum of two weeks' notice is required**.

MISSED APPOINTMENTS: Once your appointment is scheduled, you will be expected to pay your therapist's full session rate or a maximum of $75 cancellation fee unless you provide 48-hour advance notice of cancellation with the exception of extreme emergencies (accidents, emergency illnesses, etc.) If you arrive more than 15 minutes late to an appointment, the session will be considered missed unless other arrangements are worked out with your therapist and approved by the CCA director. Work conflicts would not be reasons for this fee being waived. Frequent cancellations and rescheduling may result in termination and referral by your counselor and will be discussed by phone or in person before this occurs. **If a minor child or client being covered by a guardian's insurance policy (thus making them the guarantor) incurs fees, the guardian/guarantor will be held legally responsible for any fees occurred including cancellation fees**.

COURT RELATED FEES: I have no forensic experience and being a master's level counselor or associate would generally not be considered an expert witness. If you become involved in litigation that requires my participation including but not limited to divorce, custody disputes, or cases involved CPS or criminal activity, and due to the complexity and difficulty of legal involvement, I charge **$200 per hour** for preparation, paperwork and travel for any legal proceedings. If court appearances are required, clients will be charged **$1000 for a half day and $2000 for an entire day**. Also, **a $1500 retainer** will be required up front if a subpoena is issued or court appearances are requested. If a client is involved in a lawsuit that creates a situation where we are court ordered to be involved we are happy to bill the initiating party for services rendered. If the charges are not paid at the time of services rendered, the fees will become the client's responsibility.

PAYMENT METHODS: You will be expected to pay for each session before it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to at the time these services are requested. Payment can be made in the form of card, cash, personal check, or flexible spending account. If you prefer to pay by credit card, there will be a $3.00 processing fee added to amounts up to $199.00, and a $5.00 processing fee for amounts over $200.00. ***Sessions will be discontinued if an outstanding balance develops without the establishment of payment arrangements and an interest rate of 18 % will be added to all outstanding balances including those created by returned checks***. **There is a $25 returned check policy.** Committing check fraud is a felony and if a returned check is not cleared within a month, this matter may be turned over to the Collin County District Attorney's Office for Prosecution and will definitely be turned over to our check recovery service. If an unpaid balance does occur, this can be turned over to a credit recovery service which may report medical collections to the standard credit reporting agencies adversely affecting a client(s)' credit score.

Clients' Initials_____ _____

COMMUNITY **C**OUNSELING **A**SSOCIATES
1506 N. Greenville Ave, Suite 200, Allen, TX 75002
214-509-6888

Notice of Policies and Practices to Protect the Privacy of Your Health Information
THIS NOTICE DESCRIBES HOW COUNSELING AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization
We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization
We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against one of our counselors with the State Board of Licensed Professional Counselors, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
- **Serious Threat to Health or Safety:** If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may

disclose relevant confidential mental health information to your emergency contact or medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Counselor's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at this office. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counselor's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post notice of such revision on our practice web site, http://www.allencounselingassociates.com . We may also elect to notify you by mail at the billing address which you have provided to us.

V. Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact:

Michelle Nietert, M.A., LPC Supervisor, Privacy Officer for CCA
1506 N. Greenville Ave, Suite 200, Allen, TX 75002
215-509-6888

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

Notice to Clients

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. Please call 1-800-821-3205 for more information.

Texas Behavioral Health Executive Council
1801 Congress Ave., Ste. 7.300
Austin, Texas 78701
Tel. (512) 305-7700

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003 .

Client Initials _____ _____

COMMUNITY **C**OUNSELING **A**SSOCIATES
1506 N. Greenville Ave, Suite 200, Allen, TX 75002
214-509-6888

COUNSELING CONTRACT

I, the client(s) signed below, affirm the accuracy of the personal information provided herein, and have read the information above and agree to the conditions set forth therein. I hereby agree to the following conditions (please initial each item):

_____ I am committed to changing my life by making positive choices.

_____ I will keep the appointment time, or will call to cancel 48 hours in advance with a legitimate excuse.

_____ I will fulfill the homework assignments.

_____ I will begin to build a support network outside of the counseling office in order to sustain personal growth.

_____ I understand that confidentiality cannot be guaranteed as indicated in the previous pages including limits regarding harm to self or others, supervision and consultation, marriage and family counseling, legal issues, and electronic communication.

_____ I understand that early termination of counseling is required in writing and it is most beneficial to exit counseling with a closure session.

_____ I understand that I am financially responsible for any fees/co-payments incurred. I am also responsible for any fees not covered due to my not following the procedures set up by my insurance provider if applicable or not providing the information in a timely manner for billing purposes. I understand that I am responsible for any fees not covered by insurance. I also understand that if I am the guarantor of a minor/client, I am responsible for any fees they may incur.

_____ I understand that if I am seeing an Associate/Counseling Student that they are being supervised by Michelle Nietert, LPC Supervisor.

_____ I also acknowledge receipt of **Notice of Policies and Practices to Protect the Privacy of Your Health Information and CCA Informed Consent.**

_____ **I acknowledge that if I am the signing on behalf of a minor child, I am their legal guardian and have the power to give medical/psychological consent**. I have been informed a copy of my divorce decree proving the above is required for any follow up visits. I also am aware of CCA's philosophy that making a counselor reveal records or appear in court is rarely therapeutic for children participating in therapy because it destroys their safe place.

(Signed)_____ (Date) _____

(Signed)_____ (Date) _____

(Guardian)_____ (Date) _____

(Counselor)_____ (Date) _____