



KELSEY VICK, LPC

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES
and
CLIENT RIGHTS AND RESPONSIBILITIES

I have reviewed this office’s Notice of Privacy Practices, which explains to me how my medical and health information may be used and disclosed. I have also reviewed my rights and responsibilities as a client receiving counseling services through Kelsey Vick, LPC. I understand that I am entitled to receive a copy of these documents at my request.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Counselor’s Signature

Date

Professional Disclosure Statement

Please initial each paragraph below in the available box indicating your understanding and acceptance of terms:

Qualifications: Kelsey Vick, M.S., is a Licensed Professional Counselor in the state of Texas (Texas License Number: 77152). Kelsey Vick, LPC is a sole-practitioner and practices in a private practice setting.

Emergency/Crisis: Please know that I do not provide a 24-hour crisis counseling service. Due to the fact that clients are scheduled one after another, it is not always possible to receive a message of an emergency or return a call immediately, but all effort is made to do so in emergency situations. A call back should come as promptly as this counselor’s situation will allow. If an after hour or weekend emergency occurs or if the urgency of your (and/or your child’s) need is such that you cannot wait for the phone call to be returned, immediately contact the Crisis Hotline at: 1-800-866-2465.

Counseling Relationship: During the time that we (this counselor with adult clients and/or minors) work together, we will meet weekly for approximately 45-55 minutes per session. Although our session may be very intimate psychologically, we have a professional relationship rather than a social one. Please do not ask me to relate to you (and/or your child) in any way other than the professional context of our counseling sessions. You (and/or your child) will best be served if our sessions concentrate exclusively on your (and/or your child) concerns.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a process of personal exploration and may lead to major changes in your (and/or your child’s) life perspectives and decisions. These changes may affect significant relationships, your (and/or your child’s) job/school, and/or your understanding of yourself (and/or that of your



FORT WORTH
COUNSELING & INTERVENTION

child). Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you (and/or your child). The following actions may lead to immediate termination of your (and/or your child's) session: arriving for the session or for a class intoxicated or under the influence of an illegal substance or threat or acts of violence towards this counselor or to other clients. I reserve the right to discontinue counseling services of clients who do not comply with the medication recommendations of the client's psychiatrist or primary care physician.

Client's Rights: Some clients need only a few counseling sessions to achieve their goals: others may require months or even years of counseling. As an adult client, or a parent/guardian of a child (given specifications of court orders), you are in complete control and may end the counseling relationship at any time though I do request that you (and/or your child) participate in a termination session. You also have the right to refuse (given specifications of court orders), or discuss modification of any of my counseling techniques or suggestions that you may believe might be harmful to you or to your child (given specifications of court orders).

My counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Board of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time, for any reason you are dissatisfied with my services, please let your counselor know so that existing issues can be worked through. If your concerns still persist, you may report your complaints to the Texas Board of Examiners of Licensed Professional Counselors, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540.

Referrals: Should you and/or I believe that a referral is needed, I will provide some alternatives, including programs and/or professionals who may be available to assist you (and/or your child).

Fees: The usual and customary rate for a counseling session is \$120.00.

You have agreed to pay \$_____ per session. I agree to provide counseling services for you or your child. The fee for each session will be due prior to the commencement of each session. The rate for all subsequent counseling services such as: phone calls over 10 minutes, etc. will be billed at \$120.00 per hour in 10 minute increments. All returned checks for non-sufficient funds will incur a \$30.00 fee.

Cancellations/No Shows: You are responsible for keeping your (and/or your child's) appointments and arriving on time. If you are late for your (and/or your child's) appointment, you will still be responsible for payment. There is a 24 hour cancellation policy. It is your responsibility to notify this counselor at least 24 hours in advanced to cancel or reschedule your (and/or your child's) appointment. **In the event that you will not be able to keep an appointment, please give notification within 24 hours in advance. If no notice is given, the standard \$120.00 fee will be charged to you. If less than 24 hour notice is provided, a \$100.00 late cancellation fee will be charged to you. After two consecutive missed appointments without notification, your (and/or your child's) regular time slot will no longer be reserved.**

Records and Confidentiality: All communications become part of the clinical record. Records are the property of Kelsey Vick, LPC. Adult client records are disposed of five years after the file is closed. Guardians or conservators do have access to child-client records and will need to sign for consent of services (within joint custody cases, only one guardian or conservator is needed to sign for consent for the child unless the court states otherwise). Minor records are disposed of five years after the client's 18th birthday. Although most therapeutic communication is confidential, limitations and exceptions do exist. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

1. You (and/or your child) are a danger to yourself (himself/herself) or someone else.
2. There is reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.
3. There is disclosure of sexual relations between a client and a mental health professional.
4. You direct Kelsey Vick, LPC, to release your records.



FORT WORTH
COUNSELING & INTERVENTION

5. Kelsey Vick, LPC, is ordered by a court judge to disclose information.

Should you request a copy of your (and/or your child's) counseling records, please be aware that a record preparation fee (\$.50/page, minimum of \$30.00) will be incurred and a "Release of Records" form must be signed. An overall counseling summary, in lieu of records, will be provided free of charge upon request. In the event that I, Kelsey Vick, must telephone you for purposes such as an appointment cancellation or to give/receive other information, efforts will be made to preserve your (and/or your child's) confidentiality. In regards to email correspondence, electronic communication will be limited to administrative issues (cancellations, rescheduling, etc.) and will not include issues related to your (and/or your child's) therapy in an effort to further preserve your (and/or your child's) confidentiality. To further protect your (and/or your child's) confidentiality, if I see you (and/or your child) in public, I will only acknowledge you (and/or your child) if you (and/or your child) approach me first. I cannot socialize with you (and/or your child). There cannot be any conversation of a clinical nature between you (and/or your child) and this counselor outside of a counseling appointment.

In cases of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge any secrets to be detrimental to the therapeutic progress.

In the unfortunate event that Mrs. Vick becomes unable to continue rendering counseling services to you (and/or your child) due to disability or death, by your signature below you are giving permission for another Licensed Professional Counselor, assigned by Kelsey Vick, LPC, to review your (and/or your child's) file for the purpose of notifying you and possibly transferring you (and/or your child) and/or clinical records to another Licensed Professional Counselor. If this is unacceptable for any reason, notify Mrs. Vick before signing this document.

Also, in the unfortunate event of your death, what becomes of your (and/or your child's) confidential records may become an issue. It is possible that several people will want Kelsey Vick to release information from it or even turn it over to them. It is in your (and/or your child's) best interest, as well as that of your family, for you to inform Mrs. Vick in advance to whom you **would** permit to release your information, **without** having a court order. You can choose to not give permission to anyone but if you do want to permit one or more people, please list them on the following lines by full name and relationship to you and/or your child (i.e. spouse, grown son/daughter, sibling, etc.).

1. _____ Relationship: _____
2. _____ Relationship: _____

Court: Kelsey Vick does not agree to serve as an expert witness or to provide testimonial services for you (and/or your child) and you agree not to cause me to be used in this way. Should you or your attorney subpoena me as a factual case witness or involve me in court-related proceeding, you agree to pay \$150.00 for every hour spent involved including case preparation, phone calls with attorneys, travel and witness time. Please be advised that should this counselor receive a subpoena to testify **DOES NOT** mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. If records are subpoenaed, this does not indicate an automatic release of records and I may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest. You further agree to pay a retainer fee of \$1,500.00 at the time the subpoena is served, to be applied toward such charges related to court proceedings. If a subpoena is issued for me it will be turned over to my attorney and I will consult with that attorney as necessary. A bill will be rendered to you for immediate payment when a subpoena is issued. Please let me know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motivations.



FORT WORTH
COUNSELING & INTERVENTION

By your signature below, you are indicating that you have fully read and understood this document, initialed pages 1-4 of this document, are in agreement that any questions you had about this document were answered to your satisfaction, and that you have received a copy of this document. By my (Kelsey Vick) signature, I verify the accuracy of this document and acknowledge my commitment to conform to its specifications.

Client’s Signature/Parent (Guardian) Signature: _____ Date _____

Kelsey Vick, M.S., LPC _____ Date _____

I hereby state that I have managing conservatorship for (dependent child’s name) _____ . I give my permission for him/her to receive counseling services from Kelsey Vick, LPC. I understand that I **MUST** provide Kelsey Vick court documentation regarding conservatorship of my child prior to services to be rendered. I understand that Kelsey Vick **WILL NOT** be able to begin counseling services without court documentation.



Child/Adolescent Counseling Logistics:

Preparation/Session Beginning: Preparing your child/teen for counseling services is a very important part to the start of a successful process. You will be given a book to read with your child (for children under the age of 12 years) before the first therapy session or this counselor will read it during his/her initial session. Your child/teen's counselor can guide you with other questions and helpful thoughts to address concerns you may have. It is important you view the play/activity room prior to your child/teen starting so that you can not only encourage the child/teen about the room, but that you also can see if there is any toy/supply that may not fit with your overall worldview. Please dialogue with your child/teen's counselor about any/all of your concerns.

Session Ending: For play/activity therapy, sometimes it may be necessary to end the session early depending upon the following circumstances: the condition or cleanliness of the playroom, the child's ability to leave when the session is over, a situation where counseling services could no longer continue (e.g., child gets sick, child breaks several toys, child chooses to leave and not return, child falls asleep, etc.), and the need for a parent consultation. Because the session may need to end early at times, please be sure to remain in the waiting room for most of the session. If you leave the waiting area please return fifteen (15) minutes prior to the scheduled ending time. For children younger than five years of age, you are asked to please remain in the waiting room at all times. Should your child/teen need to use the restroom during his/her session, your child/teen will be escorted to the restroom in the hall and this counselor will remain outside the restroom door.

For younger children in counseling: When your child greets you in the waiting room following the counseling session, it is best not to ask several questions, such as "Did you have fun?"; "What did you do?"; etc.- While playing may be a natural, pleasurable activity for your child, children in counseling are also involved in playing out problems/emotional struggles and, therefore, at times "playing" may not be so enjoyable. Additionally, because the lower areas of the brain are typically engaged in play/activity, a question of "What did you do?" usually results in an answer of "I just played" or "I don't know." Additionally, this would be similar to asking an adult in counseling what he or she did in the session-"We talked." Some helpful questions and statements you can say to your child/teen when they return from the session to show your interest and facilitate engagement could entail: "What was it like?"; commenting on the child's demeanor (e.g., "You look excited"); "What do you think you will do next time?"; "What was something in the room you liked?", etc.

Sick Policy: If your child/teen is sick, please cancel the session. If your child/teen has had a fever in the past 24-hours or has stayed home from school due to sickness, this would be a reason to cancel a session. Two cancellations for this reason are allowed and will not be billed even under the 24-hour policy rule. When a child/teen is ill, the counseling services are greatly mitigated.

Room Logistics: Children in the playroom are not asked to clean the room following the session. The reason for this is as follows: If play is a child's language and toys are the child's words; having a child clean up the playroom following the session would be analogous to asking the child to clean up his/her emotional world. It would be similar to having an adult take back everything he/she said at the end of the counseling session. This is a **unique stipulation** to utilizing play/activity in counseling-please know I am not advocating this action for other circumstances-**only play/activity counseling**.

Before a Session: Before your child attends a counseling session, please take him/her to the bathroom. Counseling can often be very emotionally freeing, causing the child sometimes to have to use the bathroom during therapy. It is helpful if the child goes to the restroom before the session begins. Also, it is recommended to bring an extra change of clothing for children undergoing potty-training or experiencing regressive behavior of any type (or children that have just mastered potty-training). Also, if your child/teen is coming from school and is hungry, please give him/her a snack before counseling starts.

Please know that the play/activity room has a variety of media that can be messy (e.g., easel paints, water-color paints, Play-Doh, clay, water, sand, etc.). Please dress your child in clothes that can tolerate mess or possible stains should the



FORT WORTH
COUNSELING & INTERVENTION

child spill paint on him/her. Also, if your child/teen is allergic to any substance that falls into this realm, it is your responsibility to let this counselor know so that appropriate modifications can be made for your child/teen.

This counselor will meet with you to give feedback on your child/teen and offer some helpful suggestions and answer questions for you as needed. While the feedback will discuss overall play/activity themes for your child/teen, discussion on several specific play behaviors or activities (for teens) will not be discussed to protect your child/teen’s confidentiality and to avoid misinterpretation. However, most certainly at times, it will be necessary to discuss specific play behaviors, exhibited during play sessions and what this may mean for your child. To better facilitate the counseling process, this counselor will ask that you complete a “Parent Update Form” for your child/teen (a sheet of paper handed to you at the start of every session to address updates, concerns, or questions).

By your signature below, you are indicating that you have fully read and understood this document, initialed pages 5-6 of this document, are in agreement that any questions you had about this document were answered to your satisfaction, and that you acknowledge your commitment to comply with all its terms, issue consent for Kelsey Vick LPC, to provide counseling services, and have received a copy of this document. By my (Kelsey Vick) signature, I verify the accuracy of this document and acknowledge my commitment to conform to its specifications.

Parent (Guardian) Signature

Date

Kelsey Vick, M.S., LPC

Date

I hereby state that I have managing conservatorship for (dependent child’s name) _____.
I give my permission for him/her to receive counseling services from Kelsey Vick, LPC. I understand that I **MUST** provide Kelsey Vick court documentation regarding conservatorship of my child prior to services to be rendered. I understand that Kelsey Vick **WILL NOT** be able to begin counseling services without court documentation.



FORT WORTH
COUNSELING & INTERVENTION

CHILD/ADOLESCENT THERAPEUTIC INTAKE

Today's Date: _____ Whom may we thank for referring you to our office? _____
Child/Adolescent Name: _____ Birthdate: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip Code : _____
Home Ph#: _____ Work Ph#: _____ Cell Ph#: _____

Whom may we contact in case of emergency: Name: _____ Relationship: _____
Address: _____
Phone #: _____

Email address if you would like to be contacted for administration purposes:

GENERAL INFORMATION ON CHILD/ADOLESCENT:

Mother's Name: _____ Age: _____ Address/Phone # same as above: Yes/No
If not: Current Address: _____ City: _____ State: _____ Zip: _____

Home Ph#: _____ Work Ph#: _____ Cell #: _____

Father's Name: _____ Age: _____ Address/Phone # same as above: Yes/No
If not: Current Address: _____ City: _____ State: _____ Zip: _____

Home Ph#: _____ Work Ph#: _____ Cell #: _____

Step Parent(s)/Legal Guardian: Name(s): _____ Age(s): _____
Address/Phone # same as above: Yes/No

If not: Current Address: _____ City: _____ State: _____ Zip: _____

Home Ph#: _____ Work Ph#: _____ Cell #: _____

Child's Physician: _____ Phone# _____

Has your child ever been tested by a psychologist? Yes/No If yes, please give date and reason:

Has your child ever been placed in a psychiatric hospital? Yes/No If yes, please give date and reason:

Is your child currently in therapy/counseling? Yes/No

Has your child received therapy/counseling in the past? Yes/No

If yes, to either of the above, please fill out the following information: Reason: _____

Name of therapist/counselor: _____ Date/Length of treatment: _____

Has your child previously taken any medications for emotional/behavioral problems? Yes/No

If yes, please describe: _____



FAMILY DYNAMICS:

People currently living in the home:

Name: _____ Age: _____ Relationship to the child: _____
Name: _____ Age: _____ Relationship to the child: _____
Name: _____ Age: _____ Relationship to the child: _____
Name: _____ Age: _____ Relationship to the child: _____

EDUCATION INFORMATION:

Is your child currently enrolled in school/daycare? Yes/No

How many school's daycares has your child attended in the last year? _____

Name of school/daycare: _____ Grade: _____ Name of Teacher: _____

Describe your child's academic performance over the past school year: GOOD FAIR POOR

If POOR, please explain:

Is your child's behavior a problem in his/her school? Yes/No If yes, please describe:

HEALTH INFORMATION ON CHILD/ADOLESCENT:

Does your child have any chronic illnesses, genetic illnesses, allergies or handicaps? Yes/No

If yes, please describe:

Is your child currently being treated for any illnesses? Yes/No If yes, what type:

Is your child taking any medication at this time? Yes/No If yes, what kind:

Was your child born with a low birth weight? Yes/No

Was your child premature? Yes/No

Was your child exposed to prenatal drug use? Yes/No

If yes, what kind _____

When did your child first:

Babble _____ Sit Unassisted _____

Become Toilet Trained _____

Roll Over _____ Walk _____

Crawl _____ Talk _____



RELATIONSHIPS:

Are the child's biological parents:

___ Married/living together

___ Separated/Divorced

How long married/living together: ___

How long separated/divorced: ___

Age of child at time of separation/divorce: _____

Are the child's biological parents still living? Yes/No

If No, age of child when parent died: _____

Length of relationship with step-parent/legal guardian: _____

Describe the following relationships:

Mother and child:

Father and child:

Siblings and child:

Step Parent/Legal Guardian (or other significant relationships) and child:

BEHAVIORAL INFORMATION:

Have there been any significant events in your child's life in the past 12 months? Yes/No

If YES, please explain:

Describe your child's fears:

How does your child show affection?

How does your child show anger?

What are some of your child's favorite activities?

DISCIPLINE TECHNIQUES:

Mother:

Father:

Step Parent/Legal Guardian:



ABUSE INFORMATION:

As far as you are aware, has your child/adolescent been abused:

Physically? Yes/No If Yes, Date: _____ Was CPS notified? Yes/No Date: _____
CPS Case #: _____ Child's age at the time of the incident: _____
Who did your child first tell about the incident? _____
Name of Perpetrator: _____
Please describe:

Sexually? Yes/No If Yes, Date: _____ Was CPS notified? Yes/No Date: _____
CPS Case #: _____ Child's age at the time of the incident: _____
Who did your child first tell about the incident? _____
Name of Perpetrator: _____
Please describe:

Emotionally? Yes/No If Yes, Date: _____ Was CPS notified? Yes/No Date: _____
CPS Case #: _____ Child's age at the time of the incident: _____
Who did your child first tell about the incident? _____
Name of Perpetrator: _____
Please describe:

Neglect? Yes/No If Yes, Date: _____ Was CPS notified? Yes/No Date: _____
CPS Case #: _____ Child's age at the time of the incident: _____
Who did your child first tell about the incident? _____
Name of Perpetrator: _____
Please describe:

What was your child's reaction to the abuse/investigation/outcome: _____

Why have you decided to seek counseling at this time? _____



ABOUT YOUR CHILD'S SYMPTOMS

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

- Accident prone
- Affectionate
- Aggressive/Assaults
- Anxious/nervous/timid
- Argues/defiant
- Breaks rules/law
- Bullied by others
- Bullies/bossy of others
- Cheats
- Clowns around
- Compliant
- Complains of feeling sick
- Conflicts at school
- Conflicts at home
- Conflicts with friends
- Conflicts with authority
- Cruel to animals
- Dawdles
- Dependent/clingy
- Depressed/sad
- Destructive
- Developmentally delayed
- Difficulty with parent(s)/partner
- Disorganized
- Distractible/daydreams
- Disrupts family activities
- Drug or alcohol use
- Eating issues (i.e. obese)
- Failure in school
- Fearful/shy
- Feelings are easily hurt
- Fidgety
- Fights (gets into)
- Fire setting
- Forgetful
- Hair chewing
- Head banging
- Hitting/Biting
- Hostile
- Hyperactive
- Hypochondriac
- Imaginary playmates
- Immature
- Inappropriate sexual behaviors/masturbation
- Inattentive
- Independent
- Inflicts pain on others
- Insults others
- Interrupts
- Intimidated by others
- Irritable
- Isolates/withdraws
- Lacks concern for others
- Learning disability
- Legal difficulties
- Lethargic
- Likes to be alone
- Loss of friends
- Low frustration tolerance
- Lying/manipulates
- Moody
- Mute, refuses to speak
- Nail biting
- Needs much supervision
- Nightmares/terrors
- Noisy
- Noncompliant
- Only plays with younger playmates
- Outgoing
- Overly obedient
- Over sensitive/cries easily
- Picks on others/teases
- Pouts
- Refuses/resists/slow responding
- Restless
- Rocking or repetitive movements
- Runs away
- Self-harming behaviors
- Sexualized behavior
- Sexually active
- Smokes
- Speech difficulties
- Stealing
- Stubborn
- Suicide talk or attempt
- Swearing/talks back
- Temper tantrums/rages
- Tics-movements or noises
- Truancy
- Uncooperative
- Under-active
- Unhappy
- Violent
- Wets bed/clothes



I understand that I am responsible for any charges incurred if I fail to cancel a scheduled appointment without 24 hours advance notice

Parent or Legal Guardian’s Signature: _____ Date: _____

PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Please initial each paragraph below in the available box indicating your understanding and acceptance of terms:

Qualifications: Kelsey Vick, M.S., is a Licensed Professional Counselor in the state of Texas (Texas License Number: 77152). Kelsey Vick, LPC is a sole-practitioner and practices in a private practice setting.

Emergency/Crisis: Please know that I do not provide a 24-hour crisis counseling service. Due to the fact that clients are scheduled one after another, it is not always possible to receive a message of an emergency or return a call immediately, but all effort is made to do so in emergency situations. A call back should come as promptly as this counselor’s situation will allow. If an after hour or weekend emergency occurs or if the urgency of your (and/or your child’s) need is such that you cannot wait for the phone call to be returned, immediately contact the Crisis Hotline at: 1-800-866-2465.

Counseling Relationship: During the time that we (this counselor with adult clients and/or minors) work together, we will meet weekly for approximately 45-55 minutes per session. Although our session may be very intimate psychologically, we have a professional relationship rather than a social one. Please do not ask me to relate to you (and/or your child) in any way other than the professional context of our counseling sessions. You (and/or your child) will best be served if our sessions concentrate exclusively on your (and/or your child) concerns.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a process of personal exploration and may lead to major changes in your (and/or your child’s) life perspectives and decisions. These changes may affect significant relationships, your (and/or your child’s) job/school, and/or your understanding of yourself (and/or that of your child). Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you (and/or your child). The following actions may lead to immediate termination of your (and/or your child’s) session: arriving for the session or for a class intoxicated or under the influence of an illegal substance or threat or acts of violence towards this counselor or to other clients. I reserve the right to discontinue counseling services of clients who do not comply with the medication recommendations of the client’s psychiatrist or primary care physician.

Client’s Rights: Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As an adult client, or a parent/guardian of a child (given specifications of court orders), you are in complete control and may end the counseling relationship at any time though I do request that you (and/or your child) participate in a termination session. You also have the right to refuse (given specifications of court orders), or discuss modification of any of my counseling techniques or suggestions that you may believe might be harmful to you or to your child (given specifications of court orders).

My counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Board of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time, for any reason you are dissatisfied with my services, please let your counselor know so that existing issues can be worked through. If your concerns still persist, you



FORT WORTH
COUNSELING & INTERVENTION

may report your complaints to the Texas Board of Examiners of Licensed Professional Counselors, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540.

Referrals: Should you and/or I believe that a referral is needed, I will provide some alternatives, including programs and/or professionals who may be available to assist you (and/or your child).

Fees: The usual and customary rate for a counseling session is \$120.00.

You have agreed to pay \$_____ per session. I agree to provide counseling services for you or your child. The fee for each session will be due prior to the commencement of each session. The rate for all subsequent counseling services such as: phone calls over 10 minutes, etc. will be billed at \$120.00 per hour in 10 minute increments. All returned checks for non-sufficient funds will incur a \$30.00 fee.

Cancellations/No Shows: You are responsible for keeping your (and/or your child's) appointments and arriving on time. If you are late for your (and/or your child's) appointment, you will still be responsible for payment. There is a 24 hour cancellation policy. It is your responsibility to notify this counselor at least 24 hours in advanced to cancel or reschedule your (and/or your child's) appointment. **In the event that you will not be able to keep an appointment, please give notification within 24 hours in advance. If no notice is given, the standard \$120.00 fee will be charged to you. If less than 24 hour notice is provided, a \$100.00 late cancellation fee will be charged to you. After two consecutive missed appointments without notification, your (and/or your child's) regular time slot will no longer be reserved.**

Records and Confidentiality: All communications become part of the clinical record. Records are the property of Kelsey Vick, LPC. Adult client records are disposed of five years after the file is closed. Guardians or conservators do have access to child-client records and will need to sign for consent of services (within joint custody cases, only one guardian or conservator is needed to sign for consent for the child unless the court states otherwise). Minor records are disposed of five years after the client's 18th birthday. Although most therapeutic communication is confidential, limitations and exceptions do exist. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

1. You (and/or your child) are a danger to yourself (himself/herself) or someone else.
2. There is reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.
3. There is disclosure of sexual relations between a client and a mental health professional.
4. You direct Kelsey Vick, LPC, to release your records.
5. Kelsey Vick, LPC, is ordered by a court judge to disclose information.

Should you request a copy of your (and/or your child's) counseling records, please be aware that a record preparation fee (\$.50/page, minimum of \$30.00) will be incurred and a "Release of Records" form must be signed. An overall counseling summary, in lieu of records, will be provided free of charge upon request.

In the event that I, Kelsey Vick, must telephone you for purposes such as an appointment cancellation or to give/receive other information, efforts will be made to preserve your (and/or your child's) confidentiality. In regards to email correspondence, electronic communication will be limited to administrative issues (cancellations, rescheduling, etc.) and will not include issues related to your (and/or your child's) therapy in an effort to further preserve your (and/or your child's) confidentiality. To further protect your (and/or your child's) confidentiality, if I see you (and/or your child) in public, I will only acknowledge you (and/or your child) if you (and/or your child) approach me first. I cannot socialize with you (and/or your child). There cannot be any conversation of a clinical nature between you (and/or your child) and this counselor outside of a counseling appointment.

In cases of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between



FORT WORTH
COUNSELING & INTERVENTION

family members and I reserve the right to terminate our counseling relationship if I judge any secrets to be detrimental to the therapeutic progress.

In the unfortunate event that Mrs. Vick becomes unable to continue rendering counseling services to you (and/or your child) due to disability or death, by your signature below you are giving permission for another Licensed Professional Counselor, assigned by Kelsey Vick, LPC, to review your (and/or your child's) file for the purpose of notifying you and possibly transferring you (and/or your child) and/or clinical records to another Licensed Professional Counselor. If this is unacceptable for any reason, notify Mrs. Vick before signing this document.

Also, in the unfortunate event of your death, what becomes of your (and/or your child's) confidential records may become an issue. It is possible that several people will want Kelsey Vick to release information from it or even turn it over to them. It is in your (and/or your child's) best interest, as well as that of your family, for you to inform Mrs. Vick in advance to whom you **would** permit to release your information, **without** having a court order. You can choose to not give permission to anyone but if you do want to permit one or more people, please list them on the following lines by full name and relationship to you and/or your child (i.e. spouse, grown son/daughter, sibling, etc.).

3. _____ Relationship: _____

4. _____ Relationship: _____

Court: Kelsey Vick does not agree to serve as an expert witness or to provide testimonial services for you (and/or your child) and you agree not to cause me to be used in this way. Should you or your attorney subpoena me as a factual case witness or involve me in court-related proceeding, you agree to pay \$150.00 for every hour spent involved including case preparation, phone calls with attorneys, travel and witness time. Please be advised that should this counselor receive a subpoena to testify **DOES NOT** mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. If records are subpoenaed, this does not indicate an automatic release of records and I may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest. You further agree to pay a retainer fee of \$1,500.00 at the time the subpoena is served, to be applied toward such charges related to court proceedings. If a subpoena is issued for me it will be turned over to my attorney and I will consult with that attorney as necessary. A bill will be rendered to you for immediate payment when a subpoena is issued. Please let me know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motivations.

By your signature below, you are indicating that you have fully read and understood this document, initialed pages 1-4 of this document, are in agreement that any questions you had about this document were answered to your satisfaction, and that you have received a copy of this document. By my (Kelsey Vick) signature, I verify the accuracy of this document and acknowledge my commitment to conform to its specifications.

Client's Signature/Parent (Guardian) Signature: _____ **Date** _____

Kelsey Vick, M.S., LPC _____ **Date** _____



FORT WORTH
COUNSELING & INTERVENTION

I hereby state that I have managing conservatorship for (dependent child's name) _____.
I give my permission for him/her to receive counseling services from Kelsey Vick, LPC. I understand that I **MUST** provide Kelsey Vick court documentation regarding conservatorship of my child prior to services to be rendered. I understand that Kelsey Vick **WILL NOT** be able to begin counseling services without court documentation.

ADULT PERSONAL DATA INVENTORY

Today's Date: _____ Whom may we thank for referring you to our office? _____
Client Name: _____ Birthdate: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Ph#: _____ Work Ph#: _____ Cell Ph#: _____

Whom may we contact in case of emergency: Name _____ Relationship _____
Address _____
Phone # _____

Email address if you would like to be contacted for administrative purposes: _____

HEALTH INFORMATION:

Rate your current health: Very good _____ Good _____ Average _____ Poor _____

Are you currently being treated for any medical conditions? _____

List significant illnesses, injuries, or handicap (past and present): _____

Are you currently taking medication? Yes/No _____ If yes, please list medications:

Have you been hospitalized? Yes/No _____ If yes, please give date/reason: _____

Have you had a miscarriage or an abortion? Yes/No _____ Date: _____

Name of Primary Physician _____ Phone# _____

Please indicate if you or any family member has a history of:

Alzheimer's _____	Anemia _____
Asthma _____	Blood Clots _____
Cancer _____	Diabetes _____
Epilepsy/Seizure _____	Heart Attack _____
Heart Disease _____	Hepatitis _____
High Blood Pressure _____	HIV/AIDS _____
Liver/Kidney Problems _____	Migraines _____
Stroke _____	Tuberculosis _____
Other _____	Unknown _____



FORT WORTH
COUNSELING & INTERVENTION

Have you had counseling before? Yes/No If yes, list name of therapist, date of service, and reason for counseling:

Have you ever been tested by a psychologist? Yes/No If yes, describe: _____

RELATIONSHIP/MARRIAGE INFORMATION: Single/Married/Divorced/Other _____

Name of partner: _____ Occupation: _____

Length of relationship: _____

Length of steady dating with current partner: _____ Length of engagement: _____

Number of previous marriages and length of time: _____

Reasons for termination of previous marriages: _____

of children: _____ Ages of children: _____ How many children living at home? _____

Sexual Orientation: Heterosexual Homosexual Bisexual

Religious Affiliation: _____ Active church member? Yes/No

FAMILY BACKGROUND INFORMATION:

List your caretakers as a child and their relationship to you. If different from your natural parents, please explain:

Were your parents divorced? Yes/No If yes, what was your age at the time? _____

List the number of siblings and your place in the family (oldest, youngest, etc.): _____

As a child, was your environment consistent or did you move around frequently? Please explain:

Did your parents/caretakers have alcohol/drug related problems? If yes, describe:

Is there any family history of mental health difficulties (depression/anxiety/drug or alcohol abuse, etc.)? Yes/No

If yes please describe: _____

Were your parents/caretakers involved in spousal abuse? If yes, please describe the type of violence that occurred and the frequency: _____

What disciplinary methods did your parents/caretakers use with you as a child?

harsh reprimand _____

taking privileges away _____

spanking with hand _____

time out _____

spanking with objects _____

other _____

beating over body _____



FORT WORTH
COUNSELING & INTERVENTION

Do you feel that the type of disciplinary methods used were abusive? Yes/No

Specify types of abuse you may have experienced as a child:

Emotional _____ Physical _____ Sexual _____

Additional comments: _____

At what age did you leave home? _____

For what purpose: marriage _____ escape abuse _____
 to work _____ school _____
 other (specify) _____

Have you ever been arrested? Yes/No If yes please explain:

Describe your current problem symptoms for which you are seeking counseling at this time or any significant events that recently occurred that prompted you to seek counseling at this time:

I understand that I am responsible for any charges incurred if I fail to cancel a scheduled appointment without 24 hours advance notice.

Signature of Client

Date



ABOUT YOUR CONCERNS

Please mark all of the items that currently apply:

<ul style="list-style-type: none"> <input type="radio"/> Abuse-emotional <input type="radio"/> Abuse-neglect <input type="radio"/> Abuse-physical <input type="radio"/> Abuse-sexual <input type="radio"/> Aggression <input type="radio"/> Alcohol/Drugs <input type="radio"/> Anger <input type="radio"/> Anxiety <input type="radio"/> Arguing <input type="radio"/> Attention problems <input type="radio"/> Caffeine <input type="radio"/> Career concerns <input type="radio"/> Childhood issues (your own childhood) <input type="radio"/> Children-care <input type="radio"/> Children-custody <input type="radio"/> Children-management <input type="radio"/> Choices I have made <input type="radio"/> Codependence <input type="radio"/> Compulsive spending <input type="radio"/> Concentration problems <input type="radio"/> Confusion <input type="radio"/> Crying <input type="radio"/> Deaths <input type="radio"/> Debt <input type="radio"/> Decision making <input type="radio"/> Decreased energy <input type="radio"/> Delusions (false ideas) <input type="radio"/> Dependence <input type="radio"/> Depression <input type="radio"/> Distracted <input type="radio"/> Divorce 	<ul style="list-style-type: none"> <input type="radio"/> Eating-making myself vomit <input type="radio"/> Eating-overeating <input type="radio"/> Eating-under eating <input type="radio"/> Emptiness <input type="radio"/> Excessively worried <input type="radio"/> Failure <input type="radio"/> Fatigue <input type="radio"/> Fears <input type="radio"/> Financial problems <input type="radio"/> Friendship problems <input type="radio"/> Gambling <input type="radio"/> Grieving <input type="radio"/> Guilt <input type="radio"/> Headaches <input type="radio"/> Health <input type="radio"/> Hopeless <input type="radio"/> Hostility <input type="radio"/> Impulsive spending <input type="radio"/> Impulsiveness <input type="radio"/> Indecision <input type="radio"/> Inferiority feelings <input type="radio"/> Inhibitions <input type="radio"/> Interpersonal conflicts <input type="radio"/> Irresponsibility <input type="radio"/> Irritability <input type="radio"/> Judgment problems <input type="radio"/> Laziness <input type="radio"/> Legal matters <input type="radio"/> Loneliness <input type="radio"/> Loss of control <input type="radio"/> Low frustration tolerance <input type="radio"/> Marital conflict/affairs 	<ul style="list-style-type: none"> <input type="radio"/> Medical Concerns <input type="radio"/> Mood Swings <input type="radio"/> Nicotine <input type="radio"/> Obsessions <input type="radio"/> Outbursts <input type="radio"/> Oversensitive <input type="radio"/> Overwhelmed <input type="radio"/> Panic/Anxiety attacks <input type="radio"/> Parenting <input type="radio"/> Paranoid <input type="radio"/> Perfectionism <input type="radio"/> Phobias <input type="radio"/> Physical pain <input type="radio"/> Relationship problems <input type="radio"/> Re-marriage <input type="radio"/> Sadness <input type="radio"/> Self cutting <input type="radio"/> Self control <input type="radio"/> Self-esteem <input type="radio"/> Separation <input type="radio"/> Sexual conflicts <input type="radio"/> Shyness <input type="radio"/> Sleep-nightmares <input type="radio"/> Step-parenting <input type="radio"/> Stress <input type="radio"/> Suicidal thoughts/prior attempts <input type="radio"/> Temper problems <input type="radio"/> Violence <input type="radio"/> Weight and diet issues <input type="radio"/> Withdrawal, isolating self <input type="radio"/> Worthlessness <p>Any other concerns? _____</p> <p>_____</p>
--	--	--



FORT WORTH
COUNSELING & INTERVENTION

CREDIT CARD AUTHORIZATION

I hereby grant Kelsey Vick, LPC, permission to process credit/debit charges and fees.

This form is requested for all clients and required to be on file for billing purposes.

Client Name/s: _____

Please read all below:

Acceptable forms of payment are: cash, check, debit card or credit card.

My initials below:

_____ Without my credit/debit card present, I authorize Kelsey Vick, LPC to use my credit/debit card information (listed below) to manually process charges/fees assigned to any named individual listed above for appointments scheduled with the assigned counselor, Kelsey Vick, LPC.

_____ I authorize Kelsey Vick, LPC to charge for missed appointments, scheduled with the assigned counselor: Kelsey Vick, LPC: No Show (of which the client/s named above did not show up for session) and Late Cancellations (cancellation made less than 24 hours before the time of the appointment). No shows are billed at the customary rates of \$120.00 and late cancellations are billed at \$100.00.

Please complete all information below:

Type of Card (Circle) Master Card Visa Discover AmEx

Cardholder's Name _____

Card Number _____

Expiration Date (month/year) _____

Credit Card Code (3 digit code on back of card) _____

Billing Address _____

City _____ State _____ Zip Code _____

Email Address _____

Signature _____ Date _____



CLIENT MEDICATION LOG

Medication Name	Dosage	Start Date of Prescription	Prescribing Doctor	Counselor's Initials

Signature of Client/Client Representative

Date