Bridging Harts Psychotherapy

203 S. Alma Suite 300
Allen, TX 75013
972-562-5002

Professional Disclosure Statement

To be filled about by parent of adolescent or child

Nature of Counseling

Our approach to counseling focuses on how the influences of the past affect the decisions and interactions you are having today. Throughout your therapy, together you and we will look at the different aspects of your personality, how you were raised, the messages you received from your parents, and how you functioned in the family system. In addition, both of us will work on counseling goals, which will govern the direction of your counseling process. Through directive techniques focusing on the here and now, we will work towards fostering your self-awareness, self-responsibility, and genuineness.

Some clients need only a few counseling sessions to achieve their goals, others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though we do ask that you participate in a termination session. You also have the right to refuse or negotiate modification of any of our suggestions that you believe might be harmful. At any time, either you or I may initiate discussion of possible positive or negative effects of entering or not entering counseling, continuing or not continuing counseling, and/or using or not using certain techniques.

Sessions are usually held weekly for about 45 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to counseling sessions you arrange with me except in case of emergency when you may contact me by phone. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context or our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling

experience. However, it is important for you to remember that you are experiencing me in my professional role only. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

Referrals

If at any time, for any reason, you are dissatisfied with my service, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at 512-834-6658.

Should you and/or I believe that a referral is needed, I will provide some possible referral sources. A verbal exploration of alternatives to counseling will also be made available upon request.

Fees and Cancellation

In return for a fee of $_____ (will be agreed upon) per session, I agree to provide counseling services for you. The fee for each session will be due and must be paid at the conclusion of each session. Cash or personal checks (made out to Katrena Hart) are acceptance of payment. If the fee represents a hardship to you, please let me know.

In the event that you will not be able to keep an appointment, please cancel at least 24 hours in advance. If proper notice is not received, you are responsible for payment for the missed session.

Telephone Counseling

We as an agency want to support you at every step you are needing support. There may be times when you are needing to ask some questions, gain some reassurance, or get feedback. There will not be a charge for calls that happen once a month for a 15 minute time frame. Prior to the 15 minutes or needing support more than once a month you will be charged at your hourly rate.

Returned Checks

Checks that do not clear at the bank will need to be reimbursed within 48 hours plus a $20.00 servicing fee. If your check does not clear on 3 or more occasions you will be required to pay in cash.

Payment Policy

Clients are expected to pay for appointments on the day of the appointment. If you neglect to pay your appointment on the date of the appointment, there is an expectation that you will go on line and pay on our website on paypal. In the case that there is no payment for 2 sessions your therapist will be required to create a contract agreement with you about how to get caught up and what can be done going forward.

Court Testimony

We as an agency are not interested in appearing in court for any reason. If we are subpoenaed to testify you will be expected to pay in advance a 5,000.00 retainer fee. In the event that we are required to testify there will be a fee of 150.00 per hour for each clinical hour spent preparing, as well as, any driving time or waiting time.

If, at any time, you believe you are going to need to appear in court we are happy to refer you to a new clinician who is willing and trained to support you in this way.

Emergency Sessions

There are time's in which you may need a session during the weekend hours or on a day your clinician is not working. In the event that you need a session outside of your clinician's hours you may request an emergency session with a 15.00 fee.

Written Documentation

There are times when you may need written documentation provided. In the event that you need a letter written there will be a service charge of 25.00 for the clinician's time.

Records and Confidentiality

All of our communication becomes part of the clinical record, which is accessible to you on request. I will keep confidential anything you say to me, with the following exceptions;

a) I determine that you are a danger to yourself and/or others;
b) I am ordered by a court of law to disclose information;
c) You disclose sexual contact with another health professional;
d) You sign a release for me to tell someone else; or
e) You disclose information regarding physical harm to a minor

_____	_____
Client Signature	Clinician Signature
_____	_____
Date	Date
_____	_____
Father / (Guardian) Signature	Mother /(Guardian)Signature
_____	_____
Date	Date

Parent Form for Child or Adolescent
(For Completion by Parent)

Date_____**Referral Source**_____

Child/Adolescent
Name_____
Last First Middle
Date of Birth _____ Age _____
Social Security Number_____

In case of emergency, I authorize BHP to contact

_____
Name Home Phone Cell Phone

Legal Information

If a child is not living with both natural parents, both adoptive parents, or only one living parent, BHP requires a photocopy of the most recent legal document stating custody arrangements. Services will not be rendered if no copy is produced. Please initial here to indicate that you have read and understood this policy. _____

Is your child adopted? _____ If so, when? _____
Is your child living with _____ both natural parents _____ one natural parent _____ guardian

If applicable, please explain the custodial agreement for your child

_____
_____

Contact Information for Parent or Guardian Completing Intake

Name of Parent/Custodian(s)

_____

Relationship to Child _____ Email address_____

Address_____
Street City/State Zip Code

Home phone_____ Permission to leave message yes no
Cell phone_____ Permission to leave message yes no
Work phone _____ Permission to leave message yes no

Place of Employment
_____

Social Security Number _____

Marital Status ___ Married___ Separated ___ Divorced ___ Remarried ___ Never Married

Would you be willing to be a part of your child's therapy? _____

Contact Information for Other Parent or Guardian

Name of Parent/Custodian(s)
_____

Relationship to Child _____ Email address _____

Address_____
Street City/State Zip Code

Home phone_____ Permission to leave message _____
Cell phone_____ Permission to leave message _____
Work phone _____ Permission to leave message _____

Place of Employment
_____

Social Security Number _____

Marital Status ___ Married ___ Separated ___ Divorced ___ Remarried ___ Never Married

Would you be willing to be a part of your child's therapy? _____

Medical Information

Child's Primary Care Physician _____

Medications currently
taking_____

_____

Past medical conditions

_____

Current medical conditions

_____

Has your child ever been hospitalized? _____ If so, list dates and reasons

_____

_____

Has your child ever been seen by another counselor/psychologist? _____ If so, who and for how long?

_____

_____

Has your child ever been evaluated for psychiatric treatment? If so, explain.

_____

_____

Is there any history of psychiatric illness in your family? _____ If yes, please explain.

_____

_____

Is there any history of alcohol or drug abuse in your family? _____ If yes, please explain.

_____

_____

Information about Your Family

List the people currently living in the household:

Name	Relationship to Client	Age	Educational Level	Occupation

Immediate family members living elsewhere:

Name	Relationship to Client	Age	Educational Level	Occupation

Is there any history of physical, emotional, or sexual abuse in your family? _____ If so, please explain.

_____

_____

_____

What community resources, if any, are members of your family using? (twelve step programs, WIC, Hope's Door, City House, etc.)

_____

Concerns Bringing You to Counseling

What concerns do you have about your child?

_____

_____

_____

How long have these concerns existed?

_____

Are you seeking services for possible court advocacy (custody issues, abuse testimony, etc.).

_____

If yes, explain.

_____

_____

_____

Have others expressed concerns about your child?

_____

_____

_____

What do you think might be causing this behavior?

_____

_____

_____

Are you aware of any drug/alcohol use by your child? _____ If so, please explain.

_____

_____

_____

What have you tried to address your concerns?

Describe your child's personality.

Does your child have friends or activities that you don't approve? _____ If yes, please explain.

Describe your relationship with your child.

Have you noticed any changes in your child's grades? _____ If so, please explain.

What school or extracurricular activities is your child involved in?

What else would you like the counselor to know about you or about your child or the problems he or she is having?

_____

_____

_____

Credit/Debit Card Payment Consent Form

(A credit card is kept on file in case of missed appointments without **48** hours notice.)

Client Name _____
Print Last *First* *Middle Initial*

Name on Card if different _____

I authorize: *Bridging Harts Psychotherapy*
to charge my card for professional services for the amount of $_____ per session.

I understand that missed appointments with less than 48 hours cancellation will be charged to my account.

Type of Card: VISA MasterCard Exp. Date _____

Card Number _____ - _____ - _____ - _____

CVV Number _____

Card Holder's Billing Zip Code _____

_____ _____
Client Signature Date