CLIENT INFORMATION

Client Legal Name:_____ DOB: ____/____/_____ Age: _____
Client Preferred Name:_____ Gender: _____
Address:_____

Parent/Guardian Name:_____ Relationship to client:_____
Address:_____
Phone: (_____) _____ DOB: ____/____/_____
Parent Marital Status: ☐S ☐M ☐D ☐Other_____

Parent/Guardian Name:_____ Relationship to client:_____
Address:_____
Phone: (_____) _____ DOB: ____/____/_____
Parent Marital Status: ☐S ☐M ☐D ☐Other_____

I agree to be contacted in the following manner (check all that apply):

☐ Cell phone: (_____) _____
- ☐ Detailed message ok
- ☐ Text message ok
- ☐ Name and call back number only

☐ Work phone: (_____) _____
- ☐ Detailed message ok
- ☐ Name and call back number only

☐ Home phone: (_____) _____
- ☐ Detailed message ok
- ☐ Name and call back number only

☐ Email:_____

☐ Other:_____

☐ Mail to home

☐ I wish to receive appointment reminders by ___ email and/or ___ text message. (check one or both)
☐ I do not wish to receive appointment reminders.

How were you referred to me?_____

Insurance (please complete insurance form for both in-network and out-of-network)
☐ Private pay, no insurance use
☐ In-Network insurance (please verify coverage with your plan)
☐ Out-of-Network insurance

Acknowledgement of HIPAA/Privacy Policy:
I have received a copy of this office's Notice of Privacy Practices. (see attached in this packet)

_____
Client/Guardian Signature Date

It is the responsibility of the client (or guardian) to keep this office informed of any changes in insurance, residency &/or phone number as soon as possible.

Carolyn Mehlomakulu, LMFT-S, ATR-BC
13706 Research Blvd, Ste 114, Austin, TX 78750
Phone: (512) 660-7279 Fax: (888) 972-5053
carolyn@therapywithcarolyn.com

CONSENT FOR SERVICES

Client Name:_____ **Date:**_____

Parents/Guardians (for minor client):_____

Psychotherapy Services: Participation in therapy includes both risks and benefits, including the risk that symptoms or distress may increase during treatment. Benefits can include decreased emotional distress, greater insight and awareness, more adaptive coping skills and behaviors, and improved communication and interpersonal relationships. Therapy cannot be guaranteed and effectiveness of treatment depends on a variety of factors, including the client's level of participation and effort. The client should be aware that they have options for treatment, including no treatment at all. Attending therapy is voluntary, and client may end treatment at any time. If the client decides that they would like to seek another provider for therapy, I will provide referrals to other providers.

Length of Treatment: Length of treatment will be determined by therapist and client together and will vary based on the client's needs and severity of symptoms. If you are using health insurance to pay for services, please be advised that your insurance provider may have limits on the number of sessions that will be covered. If for any reason I feel that it is necessary or advisable to end treatment before you would like to, I will provide you with appropriate alternative referrals.

Fees: All sessions are 45-55 minutes. Payment is due and payable at the time of service. I accept cash, check, or credit card for payment. Returned checks will incur a $15 fee. For additional services, such as documentation, attending meetings, providing consultation, or phone calls longer than 15 minutes, I may charge a pro-rated amount, based on our standard session fee. In cases of failure to pay fees, I may enlist the services of a collection agency to collect outstanding debt if necessary. Fees may increase at a future date, and you will be notified in advance if fees are raised. In-network insurance will be billed directly. For out-of-network insurance, you may request a statement to seek reimbursement.

Standard session rate is **$120**. Copay/reduced rate (if applicable): $_____

Parental Involvement for Minor Clients: When a minor is the client, parents may be requested to participate in treatment through family sessions or parenting sessions. **A parent/guardian is required to remain on-site during all individual sessions of a minor client.** Parents have a legal right to request information and records about their child's treatment; however, privacy allows children and adolescents to better benefit from the therapy process as they can more openly express themselves. **By consenting to services with me, you are agreeing that I may hold your child's therapy disclosures confidential.** I will inform parents of any significant safety concerns that the minor may disclose.

Cancellation Notice: All cancellations of appointments should be made at least 24 hours in advance. If appointments are cancelled in advance there is no fee for the cancelled session. Cancellations may be left on my voicemail at (512) 660-7279. **An administrative fee of $25.00 will be charged if you give less than 24-hour notice or no-show for a scheduled appointment. This fee is not covered by any insurance companies.**

If you cancel or no-show for two consecutive sessions or stop attending therapy for two weeks without prior arrangement, your reserved appointment time may be released.

Court: I do not testify in court as a witness and do not provide court testimony for marital or custody disputes. If I am required to testify in civil court, due to court order or subpoena, I will require payment in advance of my standard fee of $150.00 per hour during the entire time at the court or at the depositions, including travel time.

Confidentiality: Information that you discuss with your therapist is usually confidential and will not be discussed with anyone not covered under the HIPAA regulations (see Notice of Privacy Policy). This means that under most circumstances what is told in a therapy session will not be reported to anyone, even to other family members (except for therapeutic purposes, in case of a minor). If you wish for information to be disclosed, you may sign a request to release information. There are limits to confidentiality under any of the following circumstances:

1. If you are a serious danger to yourself
2. If you threaten serious harm to others
3. If I have reasonable suspicion or am told of abuse or neglect of a child, elder, or dependent adult
4. If I am ordered by a court to release records or as otherwise required by law
5. If you are using a mental health insurance policy to pay for your visits, I may be required to provide certain diagnostic and treatment information in order to obtain payment for services
6. To coordinate services with your primary care provider, your psychiatrist, your referring doctor and/or other relevant providers as stated in the HIPAA regulations

All treatment records are the property of this therapist and will be stored in a secure electronic health record. You may submit a written request for your records, and I will determine whether it is appropriate to release these records.

Therapist Contact Between Sessions: You may call or email me between sessions for brief questions, concerns, or scheduling matters. I am not always able to answer the phone, so please leave a voicemail and I will make an effort to return your call within 48 hours. In the case of a psychiatric emergency or crisis, for Travis County residents, please call Psychiatric Emergency Services: (512) 472-4357. For Williamson County residents, please call the Crisis Intervention Team at (800) 841-1255. In case of immediate emergency, please call 911.

Email: Email should not be used for a crisis or emergency situation as you may not receive an immediate response. Security of email cannot be guaranteed, and you may wish to avoid the transmission of confidential information in email. If you choose to email me, you are accepting this risk.

Text Messages: Text messaging should be used for scheduling issues only. If you need to discuss anything else between sessions, please call and leave me a voicemail.

Questions and Other Rights: If you have any questions about the above information or other questions related to your treatment, please feel free to discuss this with me. If you are unhappy with your treatment at any time, I hope that you will talk with me so that I can address your concerns. You have the right to considerate, safe, and respectful therapy, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Conservator Signature (if applicable) Date

_____ _____
Parent/Guardian/Conservator Signature (if applicable) Date

_____ _____
Therapist/Witness Signature Date

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HIPAA--Notice of Privacy Policy:

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about privacy practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect December 3, 2013, and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that we maintain, including health information I created or received before I made the changes. Before I make a significant change in my privacy practices, I will change this Notice and make a new Notice available upon request.

You may request a copy of our notice at any time. For more information about my practices or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment, Payment, and Healthcare Operations: I may use or disclose your health information to a physician or other healthcare provider providing treatment for you. I may use or disclose your health information for healthcare operations, such as quality assessment and improvement activities, to review the competence or qualifications of healthcare professionals, for evaluation of practitioner and provider performance, for conducting training programs, accreditation, certification, licensing, or credentialing activities. I may use and disclose your health information to obtain payment for services I provide to you.

Your Authorization: You may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Without written authorization, I will not disclose health information unless otherwise described in this notice.

Persons Involved in Care: I may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such use or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up health information.

Marketing Health Related Services: I will not use your health information for marketing communication.

Required by Law: I may use or disclose your health information when I am required by law to do so, or if a court of law orders your records.

Abuse, Neglect, or Threats of Harm: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: I may disclose military authorities the health information of Armed Forces under certain circumstances. I may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients certain circumstances.

Appointment Reminders: I may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) as requested.

Patient Rights

Access: In most cases, you have the right to inspect and copy your medical and billing records. You must submit your request in writing. You have the right to request your records in electronic form. If you request a copy of information, I may charge a fee for the costs and time of copying. I may deny your request to inspect and copy information in some circumstances.

Disclosure Accounting: You have the right to receive an accounting of disclosures of your health information and may submit a written request for this account.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency). If paying out of pocket for services, you may restrict the release of information to your insurance provider.

Alternative Communication: You have the right to request in writing that I communicate with you about your health information by alternative means or to alternative locations. You must provide satisfactory explanation of how payments will be handled under the alternative means or locations.

Amendment: You have the right to request in writing that I amend your health information. Your request must explain the reason for amendment. I may deny your request under certain circumstances.

Right to a Copy of This Notice: You have a right to a paper copy of this notice and may request this at any time. If you received this notice electronically, you have the right to receive it in writing.

Breach of Private Health Information: You will be notified in the case of any breach of unsecured health information.

Questions and Complaints

If you want more information about my privacy practices or if you have any questions, please contact me. If you are concerned that I may have violated your privacy rights or you disagree with a decision I made about your health information, you may file a complaint in writing using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. I support your right to privacy and will not retaliate if you file a complaint.

Contact Information:
Therapist: Carolyn Mehlomakulu, LMFT-S, ATR-BC
Phone: (512) 660-7279 Fax #: (888) 972-5053
Address: 13706 Research Blvd, Ste 114, Austin, TX 78750

Carolyn Mehlomakulu, LMFT-S, ATR-BC
13706 Research Blvd, Ste 114, Austin, TX 78750
Phone: (512) 660-7279 Fax: (888) 972-5053
carolyn@therapywithcarolyn.com

CLIENT INSURANCE INFORMATION

Client Name: _____
Date of Birth: _____

1. Primary Insurance Company: _____
I.D. Number (on the front of the card):_____ Group #:_____
Policy Holder's Name:_____ DOB: ____/____/_____
Relationship to Client:_____
Behavioral/Mental Health Subcontractor (if applicable): _____

2. Secondary Insurance Company: _____
I.D. Number (on the front of the card):_____ Group #:_____
Policy Holder's Name:_____ DOB: ____/____/_____
Relationship to Client:_____
Behavioral/Mental Health Subcontractor (if applicable): _____

I hereby authorize Carolyn Mehlomakulu, LMFT-S, ATR-BC to share information to my insurance companies concerning the client's diagnosis and treatment. I hereby authorize Carolyn Mehlomakulu, LMFT-S, ATR-BC to provide treatment for me and/or my dependents and authorize payment for services.

I guarantee payment of all deductibles, copayments, coinsurance, and any services not covered by insurance. I understand that session rates, copayments, and coinsurance are set by the insurance company and are not negotiable with therapist.

I understand that insurance coverage of mental health services requires medical necessity and a mental health diagnosis. Insurance coverage cannot be guaranteed at the time of service.

I understand that it is the responsibility of the patient to keep this office informed of any changes in insurance, residency &/or phone number as soon as possible. If I do not inform this office of the changes, I must pay for all fees not covered by your current or previous insurance companies.

_____ (*initial*) **Out of network insurance (if applicable):** I understand that for out-of-network services, I am initially responsible for all payment. I may be provided with a superbill at my request that can be submitted to my insurance company for possible reimbursement. I understand that reimbursement depends on my out-of-network benefits and is not guaranteed.

_____
Client/Guardian Print Name

_____ _____
Client/Guardian Signature Date

_____ _____
Therapist Signature Date

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Authorization for Credit Card Use

It is the policy of this office to keep a credit card on file for all clients in order to ensure payment for services.

I authorize Carolyn Mehlomakulu to charge the credit card provided below for the following fees if I do not pay them in person when attending treatment:

- Therapy session fee or applicable copay/coinsurance ($120/session unless otherwise negotiated)
- Any therapy sessions or other services that are not reimbursed by insurance
- No-show and late cancellation fees ($25/session)
- Telephone calls between therapy sessions (if longer than 15 minutes), requests for records, or collateral support services.

I agree to pay for these purchases in accordance with the issuing bank cardholder agreement.

Client Name: _____

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Cardholder Signature: _____

Print Name: _____ Date: _____

I wish to receive a receipt for any payments by email. _____ (initial)

Send receipt to the following email: _____

Child Psychosocial Inventory

Parents, please complete the following information regarding your child prior to your first appointment and bring it with you to the session. Completing this form in advance will help the assessment process go more quickly. During the initial session, we will review the provided information together. You may complete this form by typing in the fields provided or by printing and completing by hand. If you are unsure of an answer or feel that a question does not apply, you may leave it blank. All information will be kept confidential.

Date:
Form completed by:

Presenting Concerns:

What are the main concerns that bring you to therapy?

How long has this been a concern?

What have you already tried to address the problem? Has anything been helpful so far?

What do you hope to get from therapy and what are your goals for therapy?

Have you noticed any changes or problems with your child's sleep, appetite, or hygiene? (Please describe)

Is there any history of trauma or upsetting life events (such as abuse, life threatening accidents or medical concerns, family conflict, bullying, divorce, death or loss of loved ones, or natural disasters)? ☐ Yes ☐ No (If yes, please describe.)

Has your child ever had psychotherapy or counseling before? ☐ Yes ☐ No (If yes, please describe.)

Has your child been given a previous psychological diagnosis? ☐ Yes ☐ No (If yes, please describe.)

Is your child currently taking any medications for emotional or behavioral reasons? ☐ Yes ☐ No
If yes, please list name of medication, dosage, and reason prescribed.

Has your child taken any other medications in the past for emotional or behavioral reasons? ☐ Yes ☐ No
If yes, please list name of medication, dosage, and reason prescribed.

Has your child ever been hospitalized for emotional or behavioral concerns? ☐ Yes ☐ No
If yes, please describe reason and provide name of hospital.

Has your child ever made suicidal statements, made suicide attempts, or self-harmed (including cutting)?
☐ Yes ☐ No (If yes, please describe.)

Do you have concerns that you child may be using drugs or alcohol? ☐ Yes ☐ No (If yes, please describe.)

Medical History:

Primary Care Doctor or Pediatrician:
Date of last physical exam:
Does your child have any allergies? ☐ Yes ☐ No (If yes, please describe.)

Please describe any past and present medical concerns or serious illnesses:

Are you aware of any sensory processing issues that your child has? ☐ Yes ☐ No (If yes, please describe.)

Has your child ever received speech therapy or occupational therapy? ☐ Yes ☐ No (If yes, please describe.)

Developmental History:

Term of pregnancy: months Birth weight:
Were there any complications with the pregnancy or delivery? ☐ Yes ☐ No (If yes, please describe.)

During pregnancy, was there any use of drugs/alcohol, exposure to domestic violence, major illnesses/accidents, or significant stressors? ☐ Yes ☐ No (If yes, please describe.)

<u>Age 0-3:</u>
Were there any delays in reaching major milestones, such as sitting up, crawling, walking, talking, and toilet training? ☐ Yes ☐ No (If yes, please describe.)

Were there any problems with feeding or sleeping? ☐ Yes ☐ No (If yes, please describe.)

What was your child's temperament and personality like as a child?

Please describe any significant stressors or events age 0-3:

<u>Age 4-6:</u>
Were there any concerns regarding developmental milestones? ☐ Yes ☐ No (If yes, please describe.)

How did your child adjust to beginning school?

How were your child's social relationships?

Please describe any significant stressors or events age 4-6:

Age 7-12:
Were there any concerns regarding development or social relationships?

Please describe any significant stressors age 7-12:

Age 13-18:
Were there any concerns regarding development or social relationships?

Please describe any stressors are 13-18:

Family Information:

Please list family members that live in the home with child, including names and ages:

Other immediate family members that live outside of the home (i.e., parents or siblings):

Primary caregivers' relationship status: ☐ Married ☐ Single ☐ Engaged ☐ Divorced
☐ Living together ☐ Partnered, living separate ☐ Separated ☐ Divorced ☐ Widowed

Caregivers' occupations and education level:

Are there family members or others that you consider part of your family's support system? Please describe.

Family religious/spiritual identification:
Does your family actively participate in religion/spirituality? ☐ Yes ☐ No
Does your family consider religion/spirituality to be a source of support? ☐ Yes ☐ No

Do you have any concerns related to family relationships/interactions, parenting/discipline, or family communication? ☐ Yes ☐ No (If yes, please describe.)

What methods do you generally use for discipline of your children?

Is there any family use of alcohol or drugs? ☐ Yes ☐ No (If yes, please describe.)

Is there any history of CPS/Department of Child and Family Services involvement, including abuse/neglect reports, investigations, or removal of child from home? ☐ Yes ☐ No (If yes, please describe.)

Has your child ever lived in another family situation (e.g., foster family, other caregivers, grandparent or kinship care, group home or residential placement)? ☐ Yes ☐ No (If yes, please describe.)

Is there any family history of mental illness (including extended family)? ☐ Yes ☐ No
(If yes, please describe.)

What do you consider to be your family strengths?

What do you feel that you need to improve or change as a family?

School Information:

Current School: Grade:

Does your child have an IEP or other special services at school? ☐ Yes ☐ No (If yes, please describe.)

Has your child been diagnosed with a learning disorder or other educational impairment? ☐ Yes ☐ No
(If yes, please describe.)

Do you have any concerns about your child's behavior or academics at school? ☐ Yes ☐ No
(If yes, please describe.)

Does your child participate in an afterschool program or other extracurricular activities? ☐ Yes ☐ No
(If yes, please describe.)

Additional Information:

What are some of the strengths and positive qualities of your child?

Is there any other information that I should know regarding your child or family?