Kat Elrod, MS LPC-S
Licensed Professional Counselor • Board Approved Supervisor

Client Information Sheet

First Name: _____ MI: _____ Last: _____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ ▢ Yes, it Is it okay to leave a message

Secondary Phone: _____ ▢ Yes, it Is it okay to leave a message

Email: _____ ▢ Yes, it Is it okay to send me email

Marital Status: Single / Married / Divorced / Separated / Widowed / Living Together Since: _____

Your Ethnicity: _____ Religion/Spirituality: _____

Occupation: _____

Employer/School: _____

Important people in your life (spouse, children, parents, partners, friends, etc):

First & Last Name	Date of Birth	Age	Relationship to you	Lives in home?

Emergency Contact

First & Last Name: _____ Relationship to you: _____

Home/Work/Cell: _____

_____ (Please initial) I agree that the above named person may be contacted in the event that I am in danger to myself or others, and/or in the event that I am injured or become sick while attending my therapy session.

Who referred you or how did you find me? _____

3355 Bee Cave Road Suite 510, Austin TX 78746 • 512-779-7101 • katelrod@gmail.com • www.katelrod.com

Client Agreement

Welcome! Counseling is a process that is propelled by the relationship between client and therapist. My purpose is to create a safe environment necessary for exploration, understanding, healing and growth. Counseling may evoke feelings, memories and thoughts that are difficult or uncomfortable to experience. The specific goals, techniques and outcomes of counseling will be dependent upon the needs, abilities and motivation of each client. It is important that we frequently discuss our relationship and any concerns you may have, so that we can work through them, or I can refer you to a better resource.

I am a Texas Licensed Professional Counselor (#62041) doing business as Kat Elrod, MS LPC, and sharing office space with a group of independently practicing clinicians. My full name is Reta Kathleen Elrod Cardwell and may be listed as such with your insurance company. Please talk to me about any issues, questions or complaints. If the issue is not resolved, you may also contact the Texas State Board of Licensed Professional Counselors at 110 West 49th Street, Austin, TX 78756 or 1-512-834-6658.

Confidentiality

- Please read the Notice of Privacy Practices. I want to emphasize that our relationship and the content of our sessions are confidential except in case of the following:
  - Suspicion of abuse or neglect to children, elderly or the disabled
  - Threat of harm to yourself or others
  - Sexual contact or exploitation by another therapist
  - Court order
  - Collecting payment for services to include credit card processing and insurance utilization
  - Communication with other health care professionals for treatment purposes
  - You have consented in writing to the release of your confidential information
- By signing this form, you authorize the release of any information necessary to process claims submitted to your insurance company and authorize payment be made to Kat Elrod, MS LPC.
- I consult regularly with licensed mental health professionals to promote the highest quality of care for my clients, and I avoid disclosing any identifying information. In the case of my unexpected death or incapacity, the custodian of my records will become Lora Ferguson, LPC-S at 512-694-9298.
- It is important to remember that our relationship is professional and never social. If I see you outside of a therapy session, I will protect your confidentiality by not acknowledging you unless you initiate. Most often, therapists and clients ignore each other in public to avoid explaining to any person present about the nature of the relationship and to avoid confusion about navigating the interaction.

Appointments

- Sessions are scheduled with me directly. You must inform me of any cancellations at least 24 hours in advance by calling 512-779-7101 and leaving a voicemail or emailing katelrod@gmail.com.
- **Failure to cancel a session without 24 hours notice will result in a missed session fee of $50 per missed appointment.** I keep the fee lower than the full session rate and apply it to all late cancellations/no shows to remove myself from determining acceptable reasons for a miss. Please note that this fee is not covered by insurance and may be higher than the amount you pay each visit. This fee is subject to change.
- If you arrive late for your appointment, the session time will not be extended. If you are more than 15 minutes late, the session will be cancelled and a missed session fee will be due. If a pattern of late arrivals and missed appointments appears, I may increase the late cancel/no show fee, remove you from my calendar and/or discontinue service.

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- My practice is not setup for crisis care. If you need immediate attention, go to your nearest emergency room, call 911, or call one of the following hotlines: 512-472-HELP, 800-SUICIDE or 800-273-TALK.

Payment

- My fee is $125 per therapy session. This fee is subject to change.
- If you are using insurance, it is your responsibility to pay deductibles, copayments, coinsurance, and any amount denied by the insurance company. I will ask for a quote before starting services in an attempt to avoid surprises, but the actual amount covered by insurance is only determined once the claim submitted has been processed. I will charge you for any amount unpaid by the insurance company.
- Payment for service is due at the beginning of session and cash or check is strongly preferred. Credit cards may be used if necessary. No session will be held if no payment is collected and sessions will be suspended if there is an outstanding balance. There is a $25 charge for all returned checks.
- A credit card pre-authorization form must be signed to pay for unpaid sessions, amounts unpaid by insurance, missed session fees and any other past due balance on your account. You may avoid your credit card being charged by paying for all fees at the time of service or time of payment request.

Electronic Communication

- No form of communication outside of session is guaranteed to be private. By using any electronic method to send messages to me, I will assume you have made an informed decision to take the risk that the message may be intercepted. Emails, text messages and phone calls are ideally for arranging or rescheduling appointments. I will not discuss your therapy or engage in counseling through these electronic means. If you send an email that is meant for discussion, I will not reply and we can address it in our next session.
- I maintain professional pages on social media sites for networking and marketing. I do not recommend you associate yourself publicly in any way to my professional pages because these sites are not confidential. Please do not contact me through social media as I will not reply and may delete any communication I deem inappropriate. If you do "like" one of my professional social media sites, I will assume you have made an informed decision about how that choice compromises your confidentiality.

Court Fees

I do not recommend using your therapy as a tool for court cases, as it will open up your personal process to dissection and interrogation. If I am ordered to appear, I require payment 72 hours in advance at the rate of $300 per hour. This includes travel, preparation, consultation, appearances and time on-call. You are responsible for any legal fees I incur related to your case (litigation issues, lack of payment, etc.).

Please request a copy of this document if needed. Sign and date below to confirm your understanding and agreement:

_____ _____

Client Signature Date

_____

Client Printed Name

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Kat Elrod, MS LPC-S
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New Client Questionnaire

Please answer the following so that I may understand a bit more about you. Thanks!

1. **Do you have any medical conditions? Please list with approximate date of diagnosis.**

2. **Are you taking any medications? Please list with dosage you are taking.**

3. **If so, who is the doctor that is managing your medication?**

4. **May I communicate with your doctor about your care? Circle Yes or No**

5. **Have you ever been suicidal, attempted suicide and/or been hospitalized? Have you ever been in counseling? Please provide time and context.**

6. **Do you use any substances? This includes alcohol, nicotine, caffeine, methamphetamines, cocaine and opioids. Please list and specify how much and how often. Also indicate if you are recovered from an addiction.**

7. **Have you ever been a victim of a crime or of abuse? Please share any abuse or trauma you have experienced.**

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8. **Has anyone in your family been diagnosed with any kind of mental disorder? Anyone who hasn't been diagnosed but you suspect might be suffering a disorder?**

9. **Please mark the following that most closely describe what you are experiencing:**

Feeling hopeless	Can't be alone	Overreacting
Thoughts of death	Avoid social situations	Violent when angry
Desire to escape	Moody	Don't show anger
Lost interest in activities	Worried/Anxious	Cheating
No energy	Panic Attacks	Jealous
Crying all the time	Financial Stress	Experiencing Flashbacks
Overeating	Muscle tension	Easily startled
Don't feel like eating	Overwhelmed	Past abuse/crime survivor
Controlled eating/dieting	Racing thoughts	Current abuse/crime
Oversleeping	Restlessness	Physical Pain
Under sleeping/Insomnia	Spending too much	Impulsive
Don't care	Drinking	Cutting/Hurting self
Feeling disconnected	Smoking	Aggressive
Lost desire for sex	Using drugs	Paranoid
Intense desire for sex	Low self-esteem	Death of loved one
Lack of focus/attention	Feelings of shame or guilt	Other:
Lonely	Irritable/Easily frustrated	
Isolated	Angry	

10. **Please state what you hope to be different by coming to counseling.**

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Notice of Privacy Practices

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

I am required by law to maintain the privacy of your protected health information (PHI). PHI includes any information I obtain that identifies you and relates to your past, present, or future physical or mental health, to the treatment/services I provide to you and/or to the payment for those services. I am required to provide you this notice of privacy practices and am required to abide by the terms of this notice. I reserve the right to change the terms of this notice at any time and you have the right to request the most current copy of my policy.

I am permitted to use and disclose your health information without your authorization for:

1. **Treatment** - activities involved in the provision, coordination, and/or management of your mental health care. This includes an LPC-Intern consulting with a clinical supervisor or an LPC consulting with another health care professional to coordinate care and/or make treatment decisions.

2. **Payment** - activities related to receiving reimbursement for my services. An example is when I submit requests for authorization and payment to your insurance company.

3. **Health Care Operations** - activities related to the performance and operation of my practice. An example is when information is necessary for insurance, audits, credentialing or other business related functions. This also includes business associates, like billing companies to submit claims to health insurance companies.

4. **Legal Requirements**

    a. **Abuse/Neglect** - I am mandated to report any suspicion of past, current and/or future abuse and or neglect of a minor, a disabled individual or an elderly person to the appropriate public authorities.

    b. **Threat of Harm** – I have the right to report any serious and imminent threat to you, another person or the public to the appropriate party and/or law enforcement.

    c. Court Order

    d. **Health Oversight** - activities such as inspections, audits, investigations, and licensure actions necessary for monitoring compliance with civil rights laws, government programs and the general healthcare system. This includes disclosures to the Secretary of the Department of Human Services in relation to my compliance with the privacy rule.

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Your Health Information Rights. You have the right to:

- Review and obtain a copy of your PHI in your medical record except for psychotherapy notes and information compiled for legal proceedings. I may deny access if I believe access could cause harm to you or another. In such situations, you have the right to have the denial reviewed by a licensed health care professional for a second opinion. I may impose reasonable, cost-based fees for copying and postage. If your records are maintained electronically, you may also request an electronic copy of your PHI.

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- Request an amendment to the PHI in your record, when that information is inaccurate or incomplete, by delivering the request in writing to my office. If I deny your request, I must provide you the denial in writing and allow you to submit a statement of disagreement for inclusion in the record. If I accept your request, I must make reasonable efforts to provide the amendment to persons I have identified as needing it and to persons I know might rely on the information to your detriment. I must also amend your record if I have received a notice to amend from another health care provider.

- Obtain an accounting of PHI disclosed during the six years preceding your request for that information. This does not include disclosures for treatment, payment or healthcare operations. This does not include your requests for disclosure. This does not include disclosures I am legally obligated to make.

- Restrict health information use and disclosure although I am under no obligation to agree to those requests. If you pay out-of-pocket for services, you may request that your PHI not be shared with your insurance company.

- I do not release PHI or sell PHI for purposes of marketing or fundraising.

- Request an alternative means or location for receiving communications of PHI by means other than what I typically employ. For example, you may request an alternate phone number or mailing address.

- Obtain a paper copy of the current Notice of Privacy Practices for PHI by making a request at my office.

- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to my office. If I deny your request, you may submit an appeal.

- Revoke any authorizations that you made previously to use or disclose information by delivering a written revocation to my office, except to the extent information or action has already been taken.

To Request Information or File a Complaint

Please contact me if you have further questions, would like more information or if you have a complaint about the handling of your PHI.

Kat Elrod, MS LPC-S
3355 Bee Cave Road, Suite 510 Austin TX 78746
Phone 512-779-7101

You may also file a complaint with the Department of Health and Human Services by visiting their website at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html or contacting:

Office of Civil Rights Region VI
1301 Young Street, Suite 1169
Dallas TX 75202
Phone 214-767-4056, Fax 214-767-0432

Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights
200 Independence Ave, S.W. Rm. 509F
Washington, D.C. 20201

I cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from this office. I also cannot, and will not, retaliate against you for filing a complaint.

I acknowledge I received a notice of privacy practices.

Client Signature

Date

Client Printed Name

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Credit Card Pre-Authorization

I, _____, authorize Kat Elrod, MS LPC to keep my signature on file and to charge the below listed credit card for services and related fees. If I am not the client receiving these services, the client's name is _____. I agree not to dispute any of these charges. It is my responsibility to provide a new credit/debit card before the below listed card expires. This authorization is valid until I provide Kat Elrod, MS LPC with written cancellation. Charges to my credit card may include the following:

- Session Attended Fees. If I fail to provide payment at time of service, I understand you will charge my credit/debit card for the amount due.
- Missed Session Fees. I understand that my credit/debit card will be charged for any session I miss and fail to give at least 24 hours notice or I "no show". This charge will occur at the time of the missed session.
- Any amount unpaid by my insurance. I understand that I am responsible for understanding my insurance benefits and paying any amount that is denied and unpaid by the insurance company.
- Any past due balance. I have agreed to pay for services as outlined in the Client Agreement and understand my credit/debit card will be charged for any past due balance on my account.

Credit Card/Pinless Debit Card Information (All Fields Required)

Exact name on Credit/Debit Card: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Credit Card Number: _____ Card Type: Visa or Mastercard

Expiration Date: _____ CVC code (last 3-4 digits on back of card): _____

Cardholder's Signature: _____ Date: _____

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