Family First Counseling, PLLC

Brandi Chiarello, MS, LPC

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brandi@family-1st-counseling.com

CLIENT INFORMATION

Client's Name_____ Today's Date_____

Age _____ Date of Birth _____ ⑥ Male ⑥ Female

Address _____City _____State _____Zip_____

E-mail _____

I, _____, understand that privacy of email exchanges cannot be guaranteed.

I (circle one) do / do not consent to receive email from my/my child's counselor.

Home Phone _____ Cell Phone _____ Work Phone _____

Where would you like me to leave you messages? Home Work Cell

If there is an emergency at the office and we must cancel your appointment, where should we call?

Home Work Cell

In the event of an emergency, whom shall we contact? _____ Relationship to Client _____

Work Phone _____ Home Phone _____ Cell Phone _____

Is the client currently in counseling elsewhere? ⑥ Yes ⑥ No If yes, please describe. _____

Has the client ever received counseling or a psychological evaluation? ⑥ Yes ⑥ No

If yes, please describe. _____

Is the client currently on probation? ⑥ Yes ⑥ No

How did you find us? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Name_____ Relationship to Client _____

Address _____City _____State _____Zip _____

E-mail _____

Age _____ Date of Birth_____Soc Sec No. _____

Work Phone _____ Home Phone _____ Cell Phone _____

Employer_____Occupation _____

Authorization and Release: I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Brandi Chiarello, MS, LPC, the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid for services rendered and/or for cancelled or missed appointments.

Signature _____

Insurance Information

*The practice is **not** in-network with insurance. Provide this information if you are interested in billing out of network.*

Name of Insurance Company _____

Policy Holder's Name _____ Policy Holder's DOB _____

Member ID _____ Group No. _____ Contact Phone No. _____

CREDIT CARD AUTHORIZATION FORM

I, _____, authorize Brandi Chiarello, MS, LPC to process the listed credit card for payment for counseling, counseling related services, and fees for no shows and same-day cancelations.

This credit card will be billed within 48 hours of service or the occurrence of a no show or same-day cancelation unless another form of payment is provided.

Type of Credit Card: **⁰ Visa** **⁰ Master Card** **⁰Discover**

Name on the Card: _____

Credit Card Number:_____

Expiration Date: _____ 3-Digit Security Code: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

I agree that the above information is true. I understand and consent for the above card information to be kept on file, and that charges may take place and I will be responsible for the fees.

_____ _____
Signature Date

_____
Printed Name

Fee Agreement for Counseling with Brandi Chiarello, LPC-S

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

☐ **Fees:** Counseling fee schedule is below. The fee for each session will be due at the time of the session. The rate for phone calls over 10 minutes will be billed at $130.00 per hour. All returned checks will incur a $35.00 return-check fee.

25 minute session	$65
50 minute session	$130
Same Day Cancel Fee	$65
No Show Fee	$130

☐ **Long Sessions** : Every 15 minute increment after 60 minutes will be billed at the rate of $30.00.

☐ **Cancellation:** In the event that you will not be able to keep an appointment, please give 24 hours advance notice. **If you miss the appointment without prior notice OR with less than 2 hour notice, then a fee of $130 will be billed to you.** If less than 24 hour notice is provided a $65 charge will be assessed.

☐ **Method of Payment** : Cash and check are the preferred method of payment. Please use this method whenever possible.

☐ **Unpaid Balances:** If unpaid balances are more than 6 months overdue, then they are subject to being transferred to a collection agency. Prior to transferring this debt you will be informed in writing and given a final opportunity to pay your balance. Partial payments are accepted as long as there is an agreement on when the balance will be paid in full.

☐ **Record Preparation Fee:** Should you request a copy of your counseling records, please be aware that a record preparation fee ($.35/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 for $15 upon request.

☐ **Court Fees:** Should you or your attorney subpoena your counselor as a factual case witness or involve your counselor in court-related proceedings, you agree to pay $260 for every hour of court related activities including case preparation, phone calls with attorneys, travel and witness time. You further agree to pay a retainer fee of $1,500 at the time a subpoena is served, to be applied toward these charges. If a subpoena is issued it will be turned over to the office's attorney and that attorney will be consulted as necessary. A bill will be rendered to you for immediate payment when a subpoena is issued.

By your signature below you are indicating that you have read and understood this document or that any questions you had about this document were answered to your satisfaction. Your signature indicates you were furnished a copy of this document that you acknowledge your commitment to comply with all of its terms and requirements that you acknowledge understanding and agreement with the fees for service.

_____ _____

Client or Parent/Guardian Signature Date

CLIENT'S ROUTINE

What kinds of physical exercise does client enjoy? How often? _____

How much coffee, cola, tea, or other caffeine does client consume each day? _____

Is client's eating restricted in any way? How? Why? _____

Bedtime _____ Wake-up time _____ Hours of sleep on an average night? _____

Dose client have any problems getting enough sleep? Please describe fully. _____

_____

CLIENT'S HEALTH

Who is client's primary care physician? _____When was the last visit? _____

Any concerns shared by the doctor? _____

Describe any client allergies _____

List all medications or drugs client takes or has taken in the last year — including prescribed and over-the-counter_____

_____

_____

Starting with birth and proceeding to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions client has had. _____

_____

_____

Is there a history of mental illness in client's family? If so, please explain.

_____

_____

Does any family member have a current or chronic illness? If so, please explain.

_____

Anything else you are concerned about?

_____

Brandi Chiarello, MS, LPC
Informed Consent

Please INITIAL each paragraph below in the available box indicating your understanding and acceptance of terms. FOR CHILDREN: There are 2 boxes present as both parents must provide written consent for treatment.

☐ ☐ **Qualifications:** Brandi Chiarello, MS is a Licensed Professional Counselor in the state of Texas.

☐ ☐ **Counseling Relationship:** Although your sessions may be very intimate psychologically, the counseling relationship is a professional relationship rather than a social one. Please do not ask your counselor to relate to you in any way other than the professional context of your counseling sessions. You will best be served if your sessions concentrate exclusively on you.

☐ ☐ **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 life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together you and your counselor will work to achieve the best possible results for you.

☐ ☐ **Clients Rights**: 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 your counseling relationship at any time though it is requested that you participate in a termination session. You also have the right to refuse or discuss modification of any of the counseling techniques or suggestions that you believe could be harmful. Your counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Boards of Examiners of Licensed Professional Counselors and the HIPAA security and privacy rules. If at any time for any reason you are dissatisfied with these services, please inform your counselor 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.

☐ ☐ **Referrals:** Should you and/or your counselor believe that a referral is needed; you will be provide some alternatives, including programs and/or people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

☐ ☐ **Records and Confidentiality:** All of your communications become part of the clinical record. Brandi Chiarello, LPC is the custodian of your clinical record. Client records are disposed of six years after the file is closed. If any event renders Brandi Chiarello incapable of maintaining client records, then they will be transferred to the custody of another counselor. Most of your communication is confidential, but 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 are a danger to yourself or someone else.

2. You disclose sexual contact with a mental health professional.
3. Brandi Chiarello is ordered by a court to disclose information.
4. You direct Brandi Chiarello to release your records.
5. Brandi Chiarello is otherwise required by law to disclose information.
6. There is a reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.

If records are subpoenaed, this office may seek a court order to overturn the subpoena should disclosure be deemed not in the client's best interest. To further protect your confidentiality, if your counselor sees you in public, you will only be acknowledged if you approach your counselor first.

In the case of marriage or family counseling, your counselor will keep confidential (within limits cited above) anything you disclose without your family member's knowledge. However, open communication is encouraged between family members, and your counselor may terminate the counseling relationship if the secret is judged to be detrimental to the therapeutic progress.

In cases of child counseling, this counselor will not keep secrets of one parent from another parent. All outgoing emails will be sent to both parents. This is in order to preserve the therapeutic process and to maintain the focus of the child counseling on the needs of the child.

☐ ☐ **Use of Technology:** Insurance billing is filed electronically which means that your private information is entered into a secured software system that sends the billing information to the insurance company. In addition, secured email will be used for communication.

☐ ☐ **Court:** Please let the office know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motivations. This LPC does not specialize in court testimony and you might be served better by a different therapist if court testimony is the goal of counseling.

By your signature below you are indicating that you have read and understood this document or that any questions you had about this document were answered to your satisfaction. By your signature you are indicating that you were furnished a copy of this document, that you acknowledge your commitment to comply with all of its terms and requirements that you issue consent for Brandi Chiarello to work with you.

_____

Client/Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date

_____

Counselor Date

MENTAL STATUS INFORMATION

Are you or your child currently thinking about suicide or harming yourself in any way? ⑥ Yes ⑥ No

Have you or your child had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ⑥Yes ⑥No

Are you or your child having any thoughts about harming anyone else in any way? ⑥Yes ⑥No

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STATEMENT OF UNDERSTANDING

I have read the above and understand the nature of service providers and the Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge

_____

Client or Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date

HEALTH PROVIDER'S STATEMENT

I have inquired to insure that the client understood the above description of the limits on confidentiality.

_____

Health Provider's Signature Date

HIPAA 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. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our office. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understood the HIPAA Notice of Privacy Practices for this office:

_____ _____

Client signature (parent or guardian if minor patient) Date

Consent for Use and Disclosure of Health Information:

I hereby permit and release Brandi Chiarello, LPC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client signature (parent or guardian if minor patient) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

For Child & Adolescent Clients Only:

Parent/Guardian Name(s) _____

⑥ Single ⑥ Married ⑥ Re-married ⑥ Divorced ⑥ Widowed

If the rights of parent/guardian are determined by a court order, a copy of the most current legal custodial order is REQUIRED PRIOR to beginning services.

If parent is re-married, step-parent Name(s)_____

Is your home the child's primary residence? ⑥ Yes ⑥ No

Have you or your child ever been involved in any type of litigation? ⑥ Yes ⑥ No

If yes, please describe _____

THESE QUESTIONS ARE IN REGARD TO OLDER CHILDREN

Is this child in a gang? ⑥ Yes ⑥ No

Has this child used drugs?⑥ Yes ⑥ No

If yes, describe which drugs, frequency, age at first use and amounts. _____

_____

Has this child ever been pregnant or fathered a child? ⑥ Yes ⑥ No

If yes, please tell what happened with each pregnancy. _____

_____

ABOUT YOUR CHILD'S EDUCATION

Age _____ Grade_____Nick Names_____Failure or Held Back? _____

Current School _____ _____

What do school personnel tell you about your child? _____

_____

GRADE	SCHOOL	AVERAGE GRADES	CITY	STATE
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

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."

- ⑥ Accident-prone
- ⑥ Affectionate
- ⑥ Aggressive/Assaults
- ⑥ Anxious/ nervous/ timid
- ⑥ Argues/ defiant/ oppositional
- ⑥ Breaks rules/ law
- ⑥ Bullied by others
- ⑥ Bullies/ bossy of others
- ⑥ Cheats
- ⑥ Clowns around
- ⑥ Compliant
- ⑥ Complains of feeling sick
- ⑥ Conflicts at school
- ⑥ Conflicts at home
- ⑥ Conflicts with friends
- ⑥ Conflicts with authority
- ⑥ Cruel to animals
- ⑥ Dawdles
- ⑥ Dependent/ clingy
- ⑥ Depressed/ sad
- ⑥ Destructive
- ⑥ Developmentally delayed
- ⑥ Difficulty with parent(s) partner
- ⑥ Disorganized
- ⑥ Distractible/daydreams
- ⑥ Disrupts family activities
- ⑥ Drug or alcohol use
- ⑥ Eating Issues (i.e. obese)
- ⑥ Failure in school
- ⑥ Fearful/shy
- ⑥ Feelings are easily hurt
- ⑥ Fidgety
- ⑥ Fights (gets into)
- ⑥ Fire setting
- ⑥ Forgetful
- ⑥ Hair chewing
- ⑥ Head banging
- ⑥ Hitting/biting
- ⑥ Hostile
- ⑥ Hyperactive
- ⑥ Hypochondriac
- ⑥ Imaginary playmates
- ⑥ Immature
- ⑥ Inappropriate sexual behaviors/ masturbation
- ⑥ Inattentive
- ⑥ Independent
- ⑥ Inflicts pain on others
- ⑥ Insults others
- ⑥ Interrupts
- ⑥ Intimidated by others
- ⑥ Irritable
- ⑥ Isolates/ withdraws
- ⑥ Lacks concern for others
- ⑥ Lacks motivation/ procrastinates
- ⑥ Lacks respect for authority
- ⑥ Learning disability
- ⑥ Legal difficulties
- ⑥ Lethargic
- ⑥ Likes to be alone
- ⑥ Loss of friends
- ⑥ Low frustration tolerance
- ⑥ Lying/ manipulates
- ⑥ Moody
- ⑥ Mute, refuses to speak
- ⑥ Nail biting
- ⑥ Needs much supervision
- ⑥ Nightmares/ terrors
- ⑥ Noisy
- ⑥ Noncompliant
- ⑥ Only younger playmates
- ⑥ Outgoing
- ⑥ Overactive
- ⑥ Overly obedient
- ⑥ Over sensitive/ cries easily
- ⑥ Picks on others/ teases
- ⑥ Pouts
- ⑥ Refuses/ resists/ slow-responding
- ⑥ Restless
- ⑥ Rocking or repetitive movements
- ⑥ Runs away
- ⑥ Self-harming behaviors
- ⑥ Sexualized behavior
- ⑥ Sexually active
- ⑥ Smokes
- ⑥ Speech difficulties
- ⑥ Stealing
- ⑥ Stubborn
- ⑥ Suicide talk or attempt
- ⑥ Swearing/ talks back
- ⑥ Temper tantrums/ rages
- ⑥ Tics-movements or noises
- ⑥ Truancy
- ⑥ Uncooperative
- ⑥ Uncoordinated
- ⑥ Under-active
- ⑥ Unhappy
- ⑥ Violent
- ⑥ Wets bed/clothes

Any other characteristics?_____

Child Counseling/Play Therapy Logistics

For play 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 play therapy could no longer continue (e.g., child gets sick, child breaks several toys, child chooses to leave and not return, 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 let Brandi Chiarello know that you are leaving. 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 play room 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 play therapy—please know your counselor is not advocating this action for other circumstances—only play therapy.

When the 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?" While playing is a natural, pleasurable activity for the child, children in play therapy are involved in playing out problems and emotional struggle and, therefore, at times "playing" may not be so enjoyable. Furthermore, when asked what the child did in play therapy, the child will typically respond, "I played." This would be similar to asking an adult in counseling what he or she did in the session - "We talked."

Before your child attends play therapy, please take him/her to the bathroom. Play therapy 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, if your child is coming from school and is hungry, please give him/her a snack before therapy starts. Only in rare circumstances will food be provided for a child in play therapy. In such a situation, this will be discussed with the caregiver and added to the treatment plan. Please know that the playroom 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 child spill paint on him/her. Also, if your child is allergic to any substance that falls into this realm, it is your responsibility to let the play therapist know so that appropriate modifications can be made for your child.

Brandi Chiarello will meet with you to give feedback on your child periodically. During parent consultation sessions you and your counselor will discuss overall themes of your child's play. To better facilitate the play therapy process, please keep Brandi Chiarello informed of any significant changes in the child's life such as changes in family structure, new medications, new behavioral symptoms, and the child's progress at home.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Signature Date

_____

Counselor Date

AGREEMENT FOR THERAPY WITH A MINOR

I, _____ and _____

- ⑥ Agree to receive therapeutic services provided by Brandi Chiarello, MS, LPC.
- ⑥ I have read, understood, and signed the informed consent related to my child's therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his/her family.
- ⑥ Furthermore, as guardian, I understand that I am expected to be an active participant in this process by meeting with the therapist at least once per month.
- ⑥ I acknowledge that I have received and understand the Notice of Privacy Practices for this office.
- ⑥ My signature below means that I understand and agree with all of the points above.

_____

Signature of parent/guardian Date

_____

Signature of parent/guardian Date