

**Office Policies**  
*Leslie Alexander, LPC*

**Payment:** Payment is expected at the time services are rendered unless other arrangements have been made. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payments. Follow up appointments will not be honored if an account has an outstanding balance.

\*\*\*If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a \$10.00 rebilling fee for every statement sent out after the first billing. There is also a \$25.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency, which will impact your credit rating.

**Standard Rates:** Fee for sessions is \$125.00 per 50-minute session or prorated accordingly. Charges for other professional services are prorated on the basis of \$125.00 per hour. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is charged at the rate of \$125.00 per hour, “portal to portal”, that is, for the time I am out of the office on your behalf.

\*\*\**Please be advised that I do not provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be ordered, fees will be charged at the rate of \$500.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. All fees of this nature are payable in advance.*

**Cancellations:** The scheduling of an appointment involves the reservation of time specifically for you. Therefore, 24 hours cancellation notice is required in order for you to avoid being charged in full for the missed session.

*Please note that insurance companies do not reimburse for missed appointments.*

**Emergencies:** If a **TRUE** emergency arises after hours, please contact our answering services at 713-866-4494, inform the operator that you have an emergency and request that your therapist be contacted immediately.

**Insurance:** Clients who carry insurance should remember that professional services are rendered and charged to the client, not the insurance company. We will provide you with a receipt, which you can submit to your insurance company for reimbursement. If arrangements have been made, we will submit claims to your primary carrier only, on your behalf. Unless prior arrangements have been made the entire fee for service remains the responsibility of the client, including any portion not reimbursed by your insurance carrier. Woodlands Family Institute does not file out-of-network insurance claims.

\*\*\**Please be aware that Third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated.*

**Children:** Unless children are seen in the context of treatment we request that you make alternative childcare arrangements during your sessions so that our full attention can be devoted to your priorities.

**Cell Phones:** We respectfully request that your cell phone be turned off during your session.

**Confidentiality:** The law protects the privacy of all communications between clients and counselors.

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In most situations we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by federal and state laws. There are other situations which require only that you provide written, advanced consent. Your signature on our **Acknowledgement Form** provides consent for those activities as follows:

We practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes such as scheduling, billing and quality assurance. All administrative staff members have been trained on how to protect your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information discussed confidential. These consultations are very common and routine and may not necessarily be mentioned in our sessions unless it seems important to our work together. If you would prefer to handle this differently please let me know.

We also have contracts with some business services, such as answering service, electronic claims processing services and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available upon request.

**All information disclosed within sessions is confidential with the following exceptions:**

- You direct me to disclose information to someone else
- If you are determined to be in imminent danger of harming yourself or someone else
- I am ordered by a court or regulatory body to disclose information
- You disclose abuse or neglect of children, the elderly, or disabled persons
- In the instance of reasonable suspicion of child or elder abuse
- The need to release information to other professionals involved in your treatment
- In proceedings in which a claim is made about one's physical, emotional, or mental condition
- When disclosure is relevant in any suit affecting the parent-child relationship. This includes divorce and child custody deliberations
- In legal or regulatory actions against a professional
- Where otherwise legally required
- If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties
- If you disclose sexual misconduct by a therapist
- To individuals, corporations or governmental agencies involved in paying or collecting fees for services (this includes insurance companies). *Please be advised that insurance reimbursement usually requires background information, including substance abuse, diagnostic criteria and treatment plan form completion. In addition, please note that most applications for health insurance include a release of information for medical records (this would include therapy/counseling records).*

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of counseling.

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**Client or Parent's/Guardian's Signature**

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**Date**

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**PSYCHOSOCIAL HISTORY**

**Client name** \_\_\_\_\_ **Client Age** \_\_\_\_\_

**Parent/Guardian name** \_\_\_\_\_

***Presenting Problems (Check all that apply):***

Adjustment Issues		Unstable mood	
Depression		Grief/loss	
Suicidal/Homicidal gesture, attempt, or ideation		Substance abuse	
Stress		Relationship issues	
Abuse (physical, emotional, sexual)		Parenting concerns	
Trauma		Psychosis	
Neglect, abandonment		Sexual dysfunction	
School/Work difficulties		Gender identity problems	
Anxiety		Other (please describe)	
Anger			

***Symptoms (Check all that apply):***

Change in appetite		Lack of boundaries	
Change in sleep patterns		Racing thoughts	
Sadness		Panic attacks	
Low self-esteem		Anger outbursts	
Lack of motivation		Poor impulse control	
Increased energy level		Physical aggression	
Social isolation		Destruction of property	
Excessive worry		Self-abusive behavior	
Excessive guilt		Erratic behavior	
Crying spells		Obsessive thoughts	
Difficulty concentrating		Compulsive behavior	
Weight loss/gain		Paranoid thoughts/delusions	
Poor hygiene		Hallucinations	
Decline in school/work performance		Alcohol or Drug dependence	
Flat emotions		Other (please describe)	
Impaired memory			

**Briefly describe presenting problem:** \_\_\_\_\_

**When did the presenting problem(s)/symptoms(s) begin?** \_\_\_\_\_

**How often are the above symptoms experienced?** \_\_\_\_\_

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On a scale of 1-10 with 1 being the least and 10 being the most, how intense are the symptoms?

1 2 3 4 5 6 7 8 9 10

Briefly describe how the above problem(s)/symptoms(s) are negatively affecting the client's:

- Daily Functioning: \_\_\_\_\_
- Family Relationships: \_\_\_\_\_
- Social Relationships: \_\_\_\_\_
- Functioning at work/school: \_\_\_\_\_

Has the client ever received any treatment for these problem(s)/symptoms(s)?     Y     N

If yes, when? Where? Who was your doctor or therapist? \_\_\_\_\_

How long did the treatment last? \_\_\_\_\_

What was the outcome of the treatment received?

Please list any history of psychiatric hospitalizations:

Date	_____	Location	_____	Outcome	_____
Date	_____	Location	_____	Outcome	_____
Date	_____	Location	_____	Outcome	_____

Family psychiatric history—please include any mental health diagnosis given to immediate family members:

Client's medial history—please briefly describe any significant illnesses, hospitalizations, surgeries: \_\_\_\_\_



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**Please list any other significant adults or children in the client's life—please include nature of relationship:**

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**Client's marital status (if applicable):**

Single \_\_\_\_\_  
Married \_\_\_\_\_ How long? \_\_\_\_\_  
Divorced \_\_\_\_\_ How long ago? \_\_\_\_\_  
Separated \_\_\_\_\_ How long ago? \_\_\_\_\_  
Widow/Widower \_\_\_\_\_ How long ago? \_\_\_\_\_  
Other \_\_\_\_\_

**Trauma/Abuse History—please describe any significant trauma(s) experienced or witnessed by the client or any significant trauma(s) within the family:**

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**Please describe any history of significant life events such as deaths, separation from parent(s), frequent moves, terminal illnesses within the family or close friendships:**

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**Relationship History (if applicable):**

Is the client currently dating? \_\_\_\_\_ at what age was your first date? \_\_\_\_\_  
Is the client sexually active? \_\_\_\_\_ at what age was your first sexual encounter? \_\_\_\_\_

**Cultural Influences**

With what ethnic/cultural group(s) does the client identify with? \_\_\_\_\_

With what ethnic/cultural group(s) does the client's family most identify? \_\_\_\_\_

Describe any cultural values or beliefs that may impact treatment: \_\_\_\_\_

**Educational History (for children and college students)**

Current school attending \_\_\_\_\_ Grade \_\_\_\_\_ Highest degree earned \_\_\_\_\_

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Average grade performance: \_\_\_\_\_

Overall motivation to attend school: \_\_\_\_\_

Extracurricular activities: \_\_\_\_\_

**Employment History (if applicable):**

Current employment status—Where, how long? \_\_\_\_\_

Positive/negative aspects of current position? \_\_\_\_\_

**Please list any special interests/hobbies/skills client has:** \_\_\_\_\_

\_\_\_\_\_

**Please list the client's strengths:** \_\_\_\_\_

\_\_\_\_\_

**Describe desired treatment goal(s):**

\_\_\_\_\_

\_\_\_\_\_

**Please share any additional information that may be important for me to be aware of:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Client or Parent/Guardian Signature

\_\_\_\_\_  
Date