Serenity Counseling, LLC
Kathleen A. Treadway, MA, LPC-S, NCC, LCDC
Kingwood, Texas
KathleenTreadway.com
713-502-8151

Intake Form

I am honored that you have selected me to provide counseling services. Please read the following policies and consent information and fill out the information.

OFFICE POLICIES
FEE SCHEDULE: Rate: $125.00 per standard 45-50 minute individual session.

CANCELLATION POLICY: From time to time scheduling changes may be needed. Please cancel/reschedule appointments at least 24 hours before your scheduled time to avoid being charged.

PAYMENT POLICY: Payment is due in full by cash or check at time of services. You are responsible for all fees. Please ask for a receipt if you will be filing out-of-network claims. Any returned check will incur a $25.00 service charge.

EMERGENCIES: I make every effort to respond to my messages promptly— calls are returned during normal business hours. Should a life-threatening emergency occur, you should call 911 or go to the nearest hospital emergency room. If you do not have insurance coverage, you can call Ben Taub Hospital at 713-793-2000 or HCPC at 713-741-5000.

FORENSIC RATES: $500.00 per hour (or portion of hour) for court testimony or deposition. $500.00 per hour for travel, waiting and preparation for testimony. For out-of –area court appearance, all transportation and lodging expenses must be paid in advance. Records review, consultations with clients, litigants, attorneys (in person or via phone), reports or any other service provided will be charged at the rate of $500.00 per hour or prorated accordingly.

COUNSELING PROCESS
I Hold a Masters Degree in Clinical Psychology. I am licensed by the state of Texas as a Licensed Professional Counselor (LPC) and am a National Credentialed Counselor (NCC). Additionally, I am a Licensed Chemical Dependency Counselor (LCDC). My credentials also include Board Certified Coach (BCC). My experience includes working with adults with issues such as substance abuse/dependence, anxiety, anger, trauma, relationship difficulties, eating disorders, parenting, grief and loss, stress, bipolar disorder, depression, LGBTIQ issues and life transitions.

Participation in counseling involves the counselor and client listening to each other, being honest with each other, and discussing concerns about the process. Effective counseling also requires that the client and counselor develop a relationship based on mutual trust and respect. Initially, counseling sometimes results in the client experiencing uncomfortable feelings or thoughts. Sometimes things get harder before they get better. This experience may affect the client's relationships with their spouse, family members, or others.

The number of sessions will depend on many factors, such as, the circumstances that are taking place in the client's life. Some clients may require only a few sessions in order to reach their goals while others may take months or longer. Each client's journey is unique. You, the client are in control and may end our professional relationship any time you choose. I will support that decision and may request that we schedule and complete a closure session.

Please be aware that I do not provide consultation, evaluation, or legal testimony in child custody, child visitation, or molestation cases. If you require these services, I will be happy to refer you to professionals who work with these issues.

CONFIDENTIALITY/RELEASE OF INFORMATION

Kathleen A. Treadway, LPC, NCC, LCDC recognizes that the importance of confidentiality of client communications in the therapeutic process is important and all information obtained confidentially will be treated as such in accordance with law and professional standards. This is not only an ethical concept but also a legal concept where certain exceptions to confidentiality exist.

I understand that Kathleen A. Treadway, LPC, NCC, LCDC may communicate confidential information when permitted or required by law. Some of the exceptions to confidentiality include:

- Reporting child or elder abuse
- Response to a legal process
- Consultation with other mental health professionals
- In conjunction with legal proceedings including licensing complaints
- In connection with third-party billing efforts
- When required by the code of ethics for professional association to which Kathleen A. Treadway belongs
- Other circumstances where release appears proper as viewed by Kathleen A. Treadway, using her best professional judgment

I also authorize Kathleen A. Treadway, LPC, NCC, LCDC to release information which in her opinion is reasonably necessary to protect myself and/or others from risk of death or serious harm. Said information may be released to whoever is reasonably necessary to accomplish protection.

I understand that Kathleen A. Treadway, LPC, NCC, LCDC may at some time be unavailable due to illness, disability or vacation.

In addition to the restrictions set in the Policies and Practices to Protect the Privacy of Your Health Information, it is also important that you know that occasionally it is helpful to consult other health and mental health professionals about a client. During any consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are commonplace and routine and may not ordinarily be mentioned in our sessions. If you would prefer to handle this differently, please let Ms. Treadway know.

The term "information" as used in this release means all information contained in written records and also information known to Kathleen A. Treadway, LPC, NCC, LCDC which may be communicated verbally.

My signature below indicates that I have read the above – Office Policies, Counseling Process, and Confidentiality/Release of Information and agree to its terms and have been provided the HIPAA Notice Form.

_____ _____

Signature of Client **Date**

CONSENT FOR TREATMENT

I give full consent for myself , _____to participate in

(Print Name)

counseling/psychotherapy until I notify Kathleen A. Treadway, LPC-S, LCDC of any changes or until it is determined treatment is no longer necessary.

_____ _____

Signature of Client **Date**

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers within the legal guidelines. I authorize and request my insurance company to pay directly to the provider of services 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 my dependents.

_____ _____

Signature of Client **Date**

Client Information

Client Name _____ Age_____ Date of Birth_____

Address_____ City/State/ZIP_____

Your Employer/School_____ Occupation_____

Home Phone_____ Cell Phone _____ Work Phone_____

Where do you prefer to receive calls? Home_____ Cell_____ Work_____ May I leave a message? Yes_____ No_____

Email _____ May I leave a message? Yes_____ No_____

Married _____ Partnered _____ Divorced_____ Separated _____Widowed_____ Single_____

Others who live in your home:

Name_____ Age_____ Relationship_____

Name_____ Age_____ Relationship_____

Name_____ Age_____ Relationship_____

Name_____ Age_____ Relationship_____

Name_____ Age_____ Relationship_____

Health Information:
List any medical conditions:

_____

_____
List any medications you are currently taking, including dosage:

_____

_____
Your Primary Care Physician:

Name:_____ Telephone number: _____

When was the last time you saw a Mental Health Provider?_____

Name:_____ Telephone number: _____

Emergency Contact:

Name_____ Relationship_____

Address_____ Phone_____