



DR. KAY SUDEKUM TROTTER
COUNSELING SERVICES

3535 Firewheel, Suite C
Flower Mound, TX 75028

TRACIE POSEHN, MS
Licensed Professional Counselor Intern
Under supervision of Dr. Kay Trotter, PhD

214-499-0396
Tracie@KayTrotter.com
www.KayTrotter.com

Adult Client Information

Today's Date _____

Home Phone _____

Cell Phone _____

Work Phone _____

Client's Name _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Age _____ Date of Birth _____

Male Female Minor Single Married Divorced Widowed

Where would you like me to leave you messages? Home Work Cell E-mail None

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

Home Work Cell E-mail None

Employer - Husband _____ Occupation _____

Employer - Wife _____ Occupation _____

Why are you seeking counseling? _____

How would you rate the intensity of the problem or concern that brought you in? (Circle number):

1 2 3 4 5
Not Intense Moderately Intense Extremely Intense

Approximately, how long have you had the current problem? _____

In what ways have you attempted to cope with this problem? _____

Are you currently in counseling elsewhere? Yes No

Have you seen another counselor before? Yes No If yes, please give a brief description of treatment

How were you referred? _____

Who may we thank for referring you? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Name _____ Relationship to Client _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Age _____ Date of Birth _____

Your payment is to be paid in full at the time of each session. Fees are subject to change every six months.

Rate for all subsequent therapy services such as: attending parent/teacher conferences, ARD meetings, classroom observations, legal depositions, interactions with insurance providers, phone calls over 5 minutes, etc., will be billed at **\$75.00** per hour in 15-minute increments.

NO-SHOW AND CANCELLATIONS POLICY: Your visit has been reserved for you, therefore **24-hour notice is required for cancellations or you will be charged your full session fee amount.**

ABOUT YOU

Where did you attend public school? _____

Did you attend college? When? Where? _____

Any plans to further your education? _____ If so, when and what? _____

ABOUT YOUR RELATIONSHIPS

Please list your marriage(s) or other important significant relationships

Significant Other's Name	Married? Yes/No	Year Begun	Year Ended	Children From This Relationship and their Ages

ABOUT YOUR FAMILY

Relative	Name	Living? Yes/No	Age or Age at Death	Deceased? Yes/No	Occupation
Father					
Mother					
Sister(s)					
Brother(s)					
Other Significant Persons					

PLEASE CHECK ANY PAST, PRESENT, OR IMPENDING SPECIAL PROBLEMS IN YOUR FAMILY

- divorce
- frequent relocations
- debilitating injuries/disabilities
- alcohol/drug abuse
- serious illness
- psychiatric disorder
- physical/sexual abuse
- financial crisis
- legal problems
- eating disorders
- attempted/completed suicide

Have you personally experienced significant family abuse? None Unsure Emotional Physical Sexual

Have you personally experienced legal problems? No Yes

Did you experience learning problems in school? None Little Substantial Constant Struggle

In general, how happy or adjusted were you growing up? Happy Average Not Happy

Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with? _____

ABOUT YOUR HEALTH

Who is your doctor? _____ When was the last visit? _____

Any concerns shared by the doctor? _____

Do you have any allergies? _____

Do you have any chronic medical concerns? _____ Please list _____

Do you have a Mental Health diagnosis? If so, which one _____

Are you under the care of a Psychiatrist? If so, whom _____

Have you been prescribed any psychotropic drugs by your Psychiatrist? Yes No

List all medications or drugs (legal or illegal) you have taken in the last year

List all diseases, illnesses, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical condition you have had.

ABOUT YOUR CONCERNS

Please mark all of the items that currently apply. Feel free to add any others under "Any other concerns."

- | | | |
|---|---|--|
| <input type="checkbox"/> Abuse-emotional
<input type="checkbox"/> Abuse-neglect
<input type="checkbox"/> Abuse-physical
<input type="checkbox"/> Abuse-sexual
<input type="checkbox"/> Aggression
<input type="checkbox"/> Anger
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arguing
<input type="checkbox"/> Attention Problems
<input type="checkbox"/> Career concerns
<input type="checkbox"/> Childhood issues
(your own childhood)
<input type="checkbox"/> Children-care
<input type="checkbox"/> Children-custody
<input type="checkbox"/> Children-management
<input type="checkbox"/> Choices I have made
<input type="checkbox"/> Codependence
<input type="checkbox"/> Compulsions
<input type="checkbox"/> Compulsive spending
<input type="checkbox"/> Concentration Problems
<input type="checkbox"/> Confusion
<input type="checkbox"/> Crying
<input type="checkbox"/> Deaths
<input type="checkbox"/> Debt
<input type="checkbox"/> Decision making
<input type="checkbox"/> Delusions (false ideas)
<input type="checkbox"/> Dependence
<input type="checkbox"/> Depression
<input type="checkbox"/> Divorce | <input type="checkbox"/> Eating-making myself vomit
<input type="checkbox"/> Eating-overeating
<input type="checkbox"/> Eating-under-eating
<input type="checkbox"/> Emptiness
<input type="checkbox"/> Failure
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fears
<input type="checkbox"/> Financial troubles
<input type="checkbox"/> Friendship problems
<input type="checkbox"/> Gambling
<input type="checkbox"/> Grieving
<input type="checkbox"/> Guilt Headaches, pains
<input type="checkbox"/> Health
<input type="checkbox"/> Hostility
<input type="checkbox"/> Impulsive spending
<input type="checkbox"/> Impulsiveness
<input type="checkbox"/> Indecision
<input type="checkbox"/> Inferiority feelings
<input type="checkbox"/> Inhibitions
<input type="checkbox"/> Interpersonal conflicts
<input type="checkbox"/> Irresponsibility
<input type="checkbox"/> Irritability
<input type="checkbox"/> Judgment problems
<input type="checkbox"/> Laziness
<input type="checkbox"/> Legal matters
<input type="checkbox"/> Loneliness
<input type="checkbox"/> Loss of control
<input type="checkbox"/> Low frustration tolerance
<input type="checkbox"/> Marital conflict
<input type="checkbox"/> Marital infidelity/affairs | <input type="checkbox"/> Medical concerns
<input type="checkbox"/> Mood swings
<input type="checkbox"/> Obsessions
<input type="checkbox"/> Outbursts
<input type="checkbox"/> Oversensitive
<input type="checkbox"/> Panic or anxiety attacks
<input type="checkbox"/> Parenting
<input type="checkbox"/> Perfectionism
<input type="checkbox"/> Phobias
<input type="checkbox"/> Relationship problems
<input type="checkbox"/> Re-marriage
<input type="checkbox"/> Sadness
<input type="checkbox"/> Self Abuse
<input type="checkbox"/> Self-control
<input type="checkbox"/> Self-esteem
<input type="checkbox"/> Separation
<input type="checkbox"/> Sexual conflicts
<input type="checkbox"/> Shyness
<input type="checkbox"/> Sleep-nightmares
<input type="checkbox"/> Step parenting
<input type="checkbox"/> Stress
<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Temper problems
<input type="checkbox"/> Violence
<input type="checkbox"/> Weight and diet issues
<input type="checkbox"/> Withdrawal, isolating
Any other characteristics?
<hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>
<hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> |
|---|---|--|

**TRACIE POSEHN, MS, LPC-INTERN,
Professional Disclosure Statement**

Qualifications: Tracie Posehn, MS is a Licensed Professional Counselor Intern (under the supervision of Dr. Kay Trotter PhD), in the state of Texas.

Nature of Counseling: My chosen framework for counseling is Existential therapy as I value personal responsibility and knowledge of self to help find meaning in life. Existential therapy is a form of psychotherapy that emphasizes the ability of individuals to fulfill their potential if provided a supportive environment, with each choice made by an individual being reflected in self perception and the treatment of others. In practice, therapy will be a process of discovering and exploring your authentic values and the meaningfulness attributed to those values, while acknowledging the anxiety associated with being true to self. I am looking forward to providing a safe and nurturing environment to help you reach your goals. Please know that I am happy to thoughtfully answer questions you may have about therapy and/or the counseling process.

Informed Consent

Emergency/Crisis: Please know that we do not provide a 24-hour crisis counseling service. Should you experience an emergency necessitating immediate mental health attention, immediately call 9-1-1 or go to the nearest emergency room for assistance.

Counseling Relationship: During the time we work together, we will meet weekly for approximately 50-minutes per session (see *play therapy section for exclusions to this time*). Although our session may be very intimate psychologically, we have a professional relationship rather than a social one. Please do not ask me to relate to you in any way other than the professional context of our counseling sessions. You will best be served if our sessions concentrate exclusively on you (adult counseling situations) or your child's concerns (parent consultations for child or adolescent counseling).

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discounting 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 we 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 (please see play therapy section for further information). As a client, you are in complete control and may end our 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 my counseling techniques or suggestions that you believe might be harmful.

If a divorce or a separation of parents has occurred, a current copy of the relevant court documents is required to begin services. If joint custody exists, the parent not bringing the child will also be invitation to participate in their child's counseling.

I assure you that my 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 my services, please let me know so that existing issues can be worked through. If I am not available to resolve your concerns, you may report your complaints to the Texas State Board of Examiners of Licensed Professional Counselors at 800-942-55440.

Referrals: Should you and/or I believe that a referral is needed; I will 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.

Fees: In return for a fee of **\$75.00** per 50-minute session (adversarial marriage counseling is \$125.00) I agree to provide counseling services for you. The fee for each session will be due prior to the commencement of each session. The rate for all subsequent therapy services such as: attending parent/teacher conferences, ARD meetings, classroom observations, interactions with insurance providers, phone calls over 5 minutes, etc. will be billed at **\$75.00** per hour in 15-minute increments. All returned checks will incur a \$25.00 return-check fee.

Cancellation: In the event that you will not be able to keep an appointment, please give notification within 24 hours in advance. If no or less than 24-hour notification is made, a regular session fee will be billed to you. If you do, at any time, intend to discontinue counseling, please inform me as soon as possible so that other clients can be serviced.

Records and Confidentiality: All of our communications become part of the clinical record. Records are the property of Dr. Kay Sudekum Trotter PLLC. Adult client records are disposed of six years after the file is closed. Minor client records are disposed of six years after the client's 18th birthday. Most of our communication is confidential, but the following limitations and exceptions do exist, if: a) you are a danger to yourself or someone else; b) you disclose sexual contact with a mental health professional; c) I am ordered by a court to disclose information; d) You direct me to release your records; e) I am otherwise required by law to disclose information; and f) there is a reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or is likely to occur.

TRACIE POSEHN, MS, LPC-INTERN
Informed Consent - Continued

If records are subpoenaed, this does not indicate an automatic release of records and we may choose to seek a court order quashing the subpoena or providing protection should disclosure be deemed not in the client's best interest. To further protect your confidentiality, if I see you in public, I will only acknowledge you if you approach me first.

In the case of marriage or family counseling, I will keep confidential (within limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic progress (i.e., please see the play therapy section for specific confidentiality concerns regarding children in play therapy and parent consultation).

Should you request a copy of your counseling records, please be aware that a \$25.00 record preparation fee will be incurred and a "Release of Records" form must be signed. An overall counseling summary, in lieu of records, will be provided free of charge upon request.

Court: I do not agree to serve as an expert witness or to provide testimonial services for you and you agree not to cause me to be used in this way. Should you, your attorney, your spouses attorney, or ex-spouses attorney subpoena me or your client file as a factual case witness or involve me in court-related proceedings, you agree to pay **\$150.00 for every hour of my time** involved including case preparation, phone calls with attorneys, travel and witness time, ect. You further agree to pay a retainer fee of **\$2,000.00** at the time a subpoena is served to be applied toward these charges. If a subpoena is issued for me it will be turned over to our attorney and I will consult with that attorney as necessary. A bill will be rendered to you for immediate payment when a subpoena is issued. Please let me know before establishing a counseling relationship if you are attending counseling for court or court-related purposes/motivations.

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 me 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 I am 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.

I will meet with you to give feedback on your child periodically. While the feedback will discuss overall play themes for your child, discussion on several specific play behaviors will not be discussed to protect the child's confidentiality. However, most certainly at times, it will be necessary to discuss specific play behaviors and what this may mean for your child. To better facilitate the play therapy process, I will ask that you complete a "Weekly Update Report" for your child, which address updates, concerns, or questions. You can download this form on-line and complete it before coming to session or paper copies are available at the office for you to complete. The "Weekly Update Report" needs to be completed for every session to address updates.

COOPERATION OF CLIENT: Client shall keep the Counselor advised of Client's whereabouts at all times, and provide the Counselor with any changes of address, phone number or business affiliation during the time period which the Counselor's services are required. Client shall comply with all reasonable requests of the Counselor in connection with therapeutic treatment. The Counselor may, set boundaries including forms of client interactions and communication including ceasing to provide services to the Client for any reason, including without limitation: refusal of Client to comply with treatment recommendations, Counselor or staff is uncomfortable working with Client or Client's failure to timely pay fees or deposits in accordance with this Agreement, subject to the professional responsibility requirements to which Counselors are subject.

TRACIE POSEHN, MS, LPC-INTERN
Informed Consent - Continued

It is further understood and agreed that upon such termination of services of the Counselor, any of Client's deposits remaining in Counselor's Account shall be applied to any balance remaining owing to Counselor for fees and/or expenses and any surplus then remaining shall be refunded to Client.

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 and that you were furnished a copy of this document, acknowledge your commitment to comply with all of its terms and requirements, issue consent for me to work with you and/or your child and acknowledge understanding and agreement with my financial obligations.

Client's Signature

Date

Counselor

Date

MENTAL STATUS INFORMATION

- Have you or your spouse/significant other ever-attempted suicide or harmed yourself in any way? Yes No
- Are you or your spouse/significant other currently thinking about suicide or harming yourself in any way? Yes No
- Have you or your spouse/significant other had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? Yes No
- Are you or your spouse/significant other having any thoughts about harming anyone else in any way? Yes No
-

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 Signature

Date

AGREEMENT FOR THERAPY

I, _____

- Agree to receive therapeutic services provided by Tracie Posehn, under the supervision of Dr. Kay Trotter PhD.
- I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both myself and my family.
- Furthermore, I understand that I am expected to be an active participant in this process.
- I acknowledge that I have received and understand the Notice of Privacy Practices for this office.
- My signature below means that I understand and agree with all of the points above.

Client Signature

Date

HEALTH PROVIDER'S STATEMENT

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

Health Provider's Signature

Date

HIPPA 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 HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA 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 Tracie Posehn 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.