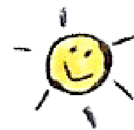

Amber Kuntz Counseling and Associates
MS, LPCS, NCC
Licensed Professional Counselors

ID

CHILD REQUEST FOR SERVICES

Child's Name: ______________________________ Nickname: ________________________

Parent Name and Address (Insured Address): ____

____

Home Phone: ________________________ Child Cell: ______________________________

Parent Cell: __________________________ Is it ok to leave a message and contact? Yes ☐ No☐

Parent name / e-mail: ____

Parent II name / e-mail: ____

Child e-mail: ___________________________________ Child DOB: ___________ Age: _____

School attended: ____

Contact Person and Phone: ____

Grade: _______ How they did on TAKS: Poor☐ Average☐ Good☐ Great☐

Other Information/ Hobbies and Interest / other's involved:

Reason for seeking services at this time?

Check the ones that pertain. Write more helpful information if you wish.

1. Biological Parents' Status:
   ☐ Married ☐ Divorced ☐ Separated ☐ Never Married
   ☐ Mother Deceased ☐ Father Deceased

2. Other reasons for seeking treatment services: Given is a list of reasons why parents bring their children here for counseling. Please check those that apply for your child.
   ☐ Learning / academic (poor grades, specific academic problems)
   ☐ Behavior Problems (temper tantrums)
   ☐ Depression or poor self esteem
   ☐ Bed Wetting
   ☐ Delinquent Behavior (stealing)
   ☐ Adjusting to divorce or blended family
   ☐ Adjusting to death of loved one
   ☐ Fears and anxiety
   ☐ Poor attention span / hyperactivity
   ☐ Aggressive behavior (towards people, animals, or property)

☐ Other Please specify:

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Please list all other member of child's immediate family including brother sisters or even step or extended that may influences or be helpful in the process.

Name	Age	Relationship	Residence
______________________	________	_____________________	___________________________
______________________	________	_____________________	___________________________
______________________	________	_____________________	___________________________
______________________	________	_____________________	___________________________

I am interested in the following counseling services: Check all that apply

☐ Individual ☐ Family ☐ Psychological Evaluation ☐ Family Coaching ☐ Testing

Has your child ever been in trouble with the law? If yes indicate the type of problem (s).
What has been done in the past to remediate this / these problem(s) or other situations?

Is the child presently taking any medication(s)? ☐Yes ☐No

Name medication(s): ____

Explain why child is on given medication(s): ____

____

How long has the child been on these medications?
Has child previously seen a Counselor, Psychologist, or Psychiatrist? ☐ Yes ☐ No

Name of past server/ Counselor:
Was support helpful: ☐ Yes ☐ No May we contact this provider: ☐ Yes ☐ No

What was helpful? ____

Why did you discontinue services with this provider? ____
If you re-requesting a Psychological Evaluation or assessment of learning problems, try to complete the following. Most schools can get you this information.

Standardized Test: ____

Test Given: ____ Date: ___________

Welcome
We appreciate you choosing our practice. You will find we are committed and passionate about helping.

Policies
Amber Kuntz, LPCS Counseling and Associates are a private counseling practice with interns, office manager, specialist, group leaders, mentors, and tutors. It is Mrs. Kuntz's policy to not release clinical records unless needed for payment. Mrs. Kuntz is here to help you, though is in no way held liable for self-inflicted harm, harm to self, suicide, and other acts of depression or anger. By signing the policies you do not hold Amber Kuntz LLC and Associates liable for you or your behaviors. You acknowledge we are here to help though, if you have a serious mental illness you may need to be

assessed by a local hospital. Warning: Therapy is not always a pleasant experience. In fact, it can be an emotional experience.
For appointments, e-mail ambercounselor@gmail.com or call 940.535.4375. There is a 24-hour cancellation policy. Therapy sessions are 45-50 minutes long. For after hours emergencies, call contact Hotline at 972-233-2233 or 911. All fees are dependent on insurance arrangement and can change.

Mrs. Kuntz and staff returns phone calls on a regular basis during office hours. You may leave a detailed message. Phone calls over 10 minutes will be billed at $2.00 per minute.

Fees and Refund Policy:
Intake session; $60.00-$85.00 depending on service and location. Package rates can be negotiated. There is no refund policy. Hypnosis is not guaranteed and there are no refunds. All policies apply in all cases. You may continue on longer at an increase in rate. **If fee is not rendered at time of service there will be a $25.00 fee attached.** If insurance is filed and the insurance company fails to pay, the client is responsible for all fees. $30 fee for bounced checks.

FINANCIAL / INSURANCE:
We ask that at each session you pay your 100% of the fee. In the event you have insurance, we will discuss at the intake who will file. If your insurance company denies payment or does not cover counseling, the client is 100% reliable for all fees. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed plus a $70.00 fee. We ask that every client authorize payment of medical benefits directly to Amber Kuntz.

Copy of chart is .35 cents per page, $35.00 per hour clerical fee, $150.00 per hour redacting fee. As noted in Hippa policies. There is a retainer fee for all court appearances. Court documentation, consultations, and other specialties should be discussed, as there are increased rates.

Whole Session: Half Session: Sliding Scale:
I have received a copy of my fee schedule ________Client Initial

24-Hour Cancellation Policy:
You will be required to pay for a "no show" or an appointment that is not cancelled within 24 hours. If you are 15 minutes late it is considered a "no show." The 24-hour cancellation policy will apply. You will be charged for that session and we will reschedule your appointment.

Solicitation:
Please refrain from any type of solicitation, enrollment, recruitment, or flirtation in this office. Any conversations that take the focus off of the services you are paying for taints the integrity of pureness of the therapy services you are paying for. In order for me to work with you effectively, you will need to come prepared to turn off cellular phones. You may bring water, but no cigarettes, drugs, or weapons. If you have something you think I may be interesting in, please put it writing and if I am interested I will contact you about it.

I understand that Amber Kuntz, LPCS and Associates may have a duty to warn. Below is a list of people (but not limited to) that can be contacted in order to help prevent harm.

Name Phone email:

___

___

INFORMED CONSENT
Thank you for choosing Mrs. Amber Kuntz, LPCS and Associates. Today's intake appointment will take approximately 30-45 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is

Amber Kuntz Counseling and Associates
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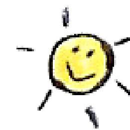

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intended to inform you of our policies, State and Federal laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Amber Kuntz and Associates practice standard therapy for most conditions, although other treatment approaches are used depending on the person and/or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today. It is the client's responsibility to discuss any concerns with the staff and to be aware that we are here to support and are not liable for emotional health. If there are signs of serious mental illness client should see a local psychiatrist or be assessed by a local hospital. Our agency is a part of the Delta Society and therefore we use a therapy dog in sessions from time to time. If you are allergic or have problems with a dog being in the office please let us know. We are certified and have had training to be able to serve you with this special service. By acknowledging the below notices you understand this statement.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:
Your verbal communication and clinical records are strictly confidential except for a) information shared with psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or your child or children report about physical or sexual abuse; then, by Texas State Law, I am obligated to report this information to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and, e) if you provide information that informs me that you are in danger of harming yourself or others, f)information necessary for case supervision or consultation, g) information you and/or your child or children report about a threat to National Security or a plot of terrorism; then, by the Homeland Security Act, under the regulations and laws of the Federal Government, I am obligated to report his information to the local authorities, and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Amber Kuntz, LPCS and Associates will follow those emergency services with standard counseling and support to the client or the client's family. Amber Kuntz, LPCS and Associates keep treatment plans on clients for all practical purposes and some billing purposes. Treatment plans are kept in client's chart. I understand that Amber Kuntz, LPCS and Associates use phone and e-mail to correspond with clients, and by signing below I waive my right for her to use these means to discuss the client being my child or myself. Special Note: If Amber Kuntz, LPCS or Associates becomes incapacitated or dies, I give my consent for the person(s) designated by Amber Kuntz to be custodian of my file and to access it for me.

CONSENT FOR TREATMENT OF CHILDREN OR ADOLSESCENTS:

I agree that ____________________may be treated by Amber Kuntz, LPCS and Associate in coordination with other professionals in the academic capacity. Signature Consent to Release Information regarding child's school: School Name, Teacher, e-mail, phone and other helpful info :

____
____
____

___________________________	________________________	__________
Parent/ Guardian Printed Name	Parent/ Guardian Signature	Date
___________________________	________________________	__________
Amber Kuntz, LPCS or Associate Printed Name	Amber Kuntz, LPCS or Associate Signature	Date

DSM
I
II
III
IV
V

Referred By:

May we send a thank you note? If so, address or email.

Amber Kuntz Counseling and Associates
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COORDINATION OF TREATMENT:

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. I release information on client

Name: ____ DOB _________________________

___You may inform my physician (s) ___I decline to inform my physician

1. Physician Name: ____________________________2. Physician Name: _______________________

Clinic / Address:____Phone:________________________

____________________________	_________________________	___________
Client /Parent/ Guardian Printed Name	Parent/ Guardian Signature	Date
____________________________	_________________________	___________
Amber Kuntz, LPCS or Associate	Amber Kuntz, LPCS or Associate	Date

Acknowledgement of Receipt of "Notice of Privacy Practices"

Please Print out and sign this page and bring it with you to your first appointment

I acknowledge that Amber Kuntz, LPCS, NCC, NBCCH, MS and/or Associates has given me a copy of the Privacy Notice either by web, email, US Mail, or in person, (version dated 4/14/03) as required by the federal government's HIPAA legislation. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information. The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164). This form documents that Mrs. Amber Kuntz, LPCS, NCC, MS has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you. The Notice contains basic information about:

1. How your counselor may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice)
2. Which uses and disclosures require authorization from you and which don't
3. How you may revoke an authorization you have made
4. Certain rights you have to restrict use and disclosure of PHI / counselor, to receive confidential communications
5. A list of my duties to protect the privacy of your PHI / counselor, my right to change the privacy policies and practices described in the Notice, and how I will inform you of changes
6. What you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make
7. Any restrictions and limitations you or I wish to put on the use and disclosure of your PHI / counselor.

This page documents that you have received a copy of the Notice that can be seen fully on line or where given to you in person.

____________________________	_________________________	___________
Client /Parent/ Guardian Printed Name	Parent/ Guardian Signature / Initial	Date
____________________________	_________________________	___________
Amber Kuntz, LPCS or Associate Printed Name	Amber Kuntz, LPCS or Associate Signature	Date

Report of Emergency conference with Parent/Guardian **Date:**

I/We have been advised that our child appears to be in a crisis situation. I/We have also been advised that we should seek further professional consultation / help. I/We have been provided with community resource information.

____________________________ _________________________ ___________

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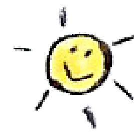

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Client /Parent/ Guardian Printed Name   Parent/ Guardian Signature / Initial   Date

_____________________________   __________________________   ___________
Amber Kuntz, LPCS or Associate   Amber Kuntz, LPCS or Associate   Date

This page is also used as your signature page as it provides signature and initials.