Preston Place Counseling
12700 Preston Road, Suite # 150
Dallas, Texas 75230

Katrina Giries, MS, LPC, NCC
Phone: 214-476-8169

Initial Interview Form & Informed Consent

CLIENT INFORMATION Date: _____

Name: _____

Phone: (wk) _____ (hm) _____ (cell) _____

May I contact you and leave messages at these phone numbers? ___Yes ___ No

Address: _____ City: _____

State: _____ ZIP: _____ Email: _____

May I mail to this address? __Yes __No May I email you? ___ Yes ___ No

Sex: ___ male ___ female Date of Birth: _____

Others living at home: _____

List any significant health problems: _____

List any medications you are taking & dosage: _____

Have you seen this type of therapist before ___ Yes ___ No

If yes, when and with whom? _____

Give a brief description of treatment: _____

How were you referred to our office? _____

Who may we thank for referring you? _____

Nearest relative other than spouse: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Client: _____

Phone (if different): _____

Address (if different): _____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION

Name: _____ Relationship to Client: _____

Phone (if different): _____

Address (if different): _____

May we contact your Emergency Contact and/or Financially Responsible party on your behalf? By contacting these people, it may be necessary to disclose confidential information about your care.

Yes_____No_____

_____ _____
Client and/or Parent/Guardian Signature Date

INFORMED CONSENT

Qualifications and Supervision:

Katrina Giries is a Licensed Professional Counselor and National Certified Counselor. Katrina Giries holds a Master of Science in Counseling from Texas A & M University – Commerce and a Bachelor of Arts in Psychology from The University of Texas at Arlington. Her focus is as a Cognitive Behavioral Therapist with a specific interest in trauma and trauma related illnesses.

CONFIDENTIALITY STATEMENT:

All information shared in this treatment is confidential except in circumstances governed by law including but not limited to the following:

- When a statement allowing release of information is signed by the client.
- When the client expresses an intent to kill or harm themselves or someone else.
- When Child/Elder abuse or neglect has occurred.
- When you or someone acting legally on your behalf have filed a complaint against me to the Texas State Board of Examiners of Professional Counselors.
- If I have been ordered by a court to appear and/or disclose information about you and our sessions.

FINANCIAL AGREEMENT

Fees are payable at the time of service. Your fee per session is $ 145.00 per 50 minute session. Your regular fee will be charged for any additional professional services rendered at your request, such as phone contacts over 5 minutes, consults with other professionals, etc.. Court Appearances are a minimum of $500 per appearance. We accept cash, check, and all major credit cards.

Insurance

I do not accept insurance for counseling services. Services are all self paid and payment is expected at the time of service. Upon request, I can supply you with a summary receipt of services which you may choose to submit directly to your insurance company for potential reimbursement.

NO-SHOW AND CANCELLATION POLICY

Your session has been reserved for you. 24 hours notice is required for cancellation or you will be charged a late cancellation fee of a full session fee. You may leave a message with my office 24 hours a day, 7 days a week.

Complaints

It is always my goal to provide professional and ethical services. If you are ever dissatisfied with my services, I encourage you to discuss it with me first to see if I can resolve your concern. However, if that is not satisfactory to you, you are also welcome to contact the Texas State Board of Examiners of Professional Counselors at the following address:

1100 West 49th Street
Austin, Texas 78756-3183
1(800) 942-5540

EMERGENCIES

If it is a potential life-threatening emergency, please go to your local emergency room. For non-life threatening emergencies, you may contact me at 214-476-8169. Calls received after 2 pm Monday – Friday may not be returned until the next business day.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Client acknowledges that he/she understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), the client have certain rights to privacy regarding Protected Health Information (PHI) and that this PHI can and will be used to:

- Conduct, plan and direct client treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Client understand that they may request in writing that the therapist restrict how my PHI is used or disclosed to carry out treatment, payment or health care operations. Client also understands you are not required to agree to client requested restrictions.

STATEMENT OF UNDERSTANDING

I have read and understand this information sheet and informed consent. I have been provided an opportunity to retain a copy of this informed consent document.

Client _____ Date _____

Provider _____ Date _____

Parent of Guardian if minor _____ Date _____