

Dear Family,

Welcome to the Center for Social Success! We appreciate your choice of our therapists to address your family's social, emotional and behavioral needs.

We offer individual and group therapy sessions for children and adults to address a variety of issues including social skills, anger management, stress management, depression, organizational skills, sibling rivalry, dealing with divorce, parenting skills, and marital enrichment. We also offer Biofeedback for anxiety and stress management.

Prior to participating in group or individual sessions, initial evaluations are necessary. During the initial evaluation, it will be determined which therapeutic approach would best suit your family's needs. For a breakdown of costs, please see the enclosed fee schedule.

Insurance coverage depends upon your carrier. We are not a designated provider on any plan nor do we file claims. You may relay the information below to your insurance carrier to determine if these services are reimbursable under your plan:

Licensing: Susan M. Istre, PhD, LPC-S, Director of the Center for Social Success

Diagnosis Code: Unless previously diagnosed (i.e. ADHD, PDD, Depression, etc.), a diagnosis will be determined at initial appointment.

Service Codes: 90801-Diagnostic Interview w/Parents or Client, 50 mins.
 Diagnostic Interview w/Child, 30-50 mins.
 90830-Psychological Testing, 50 mins. (not applicable with adults)
 90806-Individual Therapy, 50 mins.
 90853-Group Therapy, 8-19 sessions per group at 50 mins. Each
 90846-Family Therapy without Patient Present, 50 mins.
 90847-Family Therapy with Patient Present, 50 mins.

I hope this information is helpful. If you have any questions, please do not hesitate to contact my office at 972-404-3001.

Susan M. Istre, PhD

Dr. Susan M. Istre

Dr. Susan Istre, LPC-S, Director ▲▲▲ Center for Social Success
 12880 Hillcrest J105, Dallas, Tx 75230 ▲▲▲ 972-404-3001 ▲▲▲ Fax: 972-404-3005



Fee Schedule and Billing Information

Session rates for Individual and Family therapy:

Dr. Susan Istre, LPC-S: \$150.00
 Erin Lozano, LMSW: \$140.00
 Holly Fedro, LCSW: \$140.00
 Cottie Alders, LMSW: \$140.00
 Natalie Thomas, MS, LPC: \$140.00

Interns

Supervised by Dr. Susan Istre, LPC-S
 Tara Cavanaugh, LPC – Intern - \$120.00
 Angelica Moore, LPC-Intern - \$120.00
 Jennifer Storm, LPC – Intern - \$120.00

Session rates for Group Therapy: \$75.00

Court fees: 2.5 x normal therapist rate

Initial Evaluation Fees: Depending upon the service requested, there may be additional fees for new appointments. **PLEASE CLARIFY WITH THE FRONT OFFICE WHAT ADDITIONAL COSTS TO EXPECT FROM YOUR INITIAL EVALUATION.**

Intern Supervision: All interns are supervised weekly by Dr. Istre and have received extensive training in child, family and/or marital therapy.

Phone calls: Brief phone calls (5-10 minutes) to parents, teachers, or other professionals are not charged. Longer calls are charged at the same rate as individual talk therapy and billed according to time spent.

Parent feedback: Parents need to schedule individual sessions monthly for extensive feedback and behavioral advice. Parent appointments are vital to a successful outcome. Face to face or phone appointments are available.

Fees at our Shelton satellite offices: Payment in advance or credit card billing is required for services provided off site. A credit card is required to be kept on file at our LBJ office.

Bills and Payment Options:

We accept cash, checks (both personal and business), Visa MasterCard, and Discover.

For your convenience, we offer automatic credit card billing. On the fifteenth and last day of every month, your account balance will be charged to your credit card. You will then be mailed a receipt and zero balance bills which you may submit to your insurance company. Authorization for automatic credit billing is maintained with your records in a secured location within the office. To complete this form, please see page 8.

If you do not choose the credit card option, payment will be due at the time services are rendered. You will receive a paid receipt that may be used to file with your insurance company. Services received outside the LBJ location require payment through automatic credit card debit.

Insurance:

The Center for Social Success does not file insurance claims. The paid receipt you will receive contains the information required to file with your insurance company. The insurance company should send payments directly to you. The Center for Social Success will not accept insurance payments. Checks received by the Center for Social Success will be voided and returned to the insurance company for reissue to the insured.



Signature Form

Permission for Treatment and Release of Records

I consent to the use and disclosure of my protected health information to carry out treatment, financial activity, and health care operations at the Center for Social Success by the staff of the Center for Social Success. I understand I have the right to read the Center for Social Success's Notice of Privacy Practices before deciding to sign below. This notice is available upon request at the Center for Social Success. I give permission for the Center for Social Success to mail information to my home or other designated locations: I also give permission to be contacted at provided phone numbers, e-mail and to leave a message on the voice mail.

If I am divorced, I verify that I have medical rights to obtain psychological treatment for my child or children. I understand that if my spouse also has medical rights, he or she will have access to his or her children's charts but no access to my session notes and information.

Permission for Testing

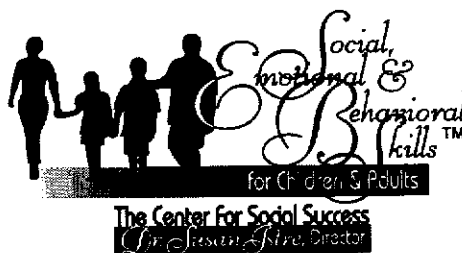
I give permission for an assessment to be made of my own or my child's attentional, social and/or psychological behavior. I understand that this assessment may involve examination of records and reports (provided by the client or sent at the request of the client), gathering of developmental, educational, and social information by reports and rating scales. I understand that an appointment will subsequently be held in which the findings and recommendations of this assessment will be discussed.

I understand that all information will be handled in confidence and release will be limited to authorized personnel and/or to others I have designated by signing the Release of Information included in this packet.

Patient's Name: (please print) _____

Patient's Parent or Guardian's Signature: _____

Date: _____



Statement of Professional Disclosure

I am required by law to furnish you with information about my professional credentials. I am licensed to practice as a Licensed Professional Counselor by the Texas State Board of Examiners. My license number is 10940. I obtained my Ph.D. from Oklahoma State University in Family Relations and Child Development. I will be happy to discuss my education and/or credentials further with you, if you desire, or you may review my curriculum vitae online at www.dristre.com. You may contact (without giving your name) the LPC office listed below for additional information.

Texas State Board of Examiner of Professional Counselors
 1100 West 49th Street
 Austin, Texas 78756-3183
 1/512-834-6658

We also employ social workers (LMSW & LCSW) as staff therapists. Although they are not required by law to inform clients of their credentials, we will be happy to provide this information upon request. Dr. Istre is also a state approved LPC supervisor and has interns working at the clinic. She meets with interns weekly to review cases.

Susan M. Istre, Ph.D.

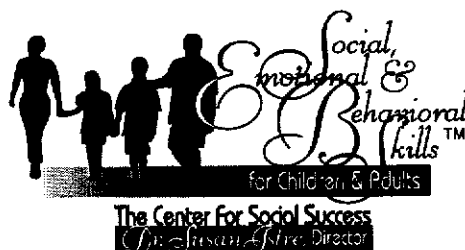
Susan M. Istre, Ph.D., L.P.C.-S

The above signed counselor has satisfactorily supplied me with information regarding her professional credentials. I understand I can request more information about the credentials of other staff members, if desired.

Patient's Name: (please print) _____

Patient's Parent or Guardian's Signature _____

Date: _____



Statement of Financial Responsibility

I agree to be responsible for all charges incurred for the evaluation and treatment of my child. Unless otherwise specified, payment, in full, for all services is expected at the time of service. I further understand and agree to be responsible for submission of all claims to my insurance carrier. Statements will include all information necessary for insurance claim submission (CPT code, diagnosis code, federal tax identification number) and should be retained for insurance/tax purposes. Statements substitute for "Attending Physician's/Provider's Statement" when filing for insurance reimbursement. Dr. Istre is not responsible for filing or collecting claims or for negotiating a settlement on a disputed claim. Authorizations are not the responsibility of the Center For Social Success. Upon request and with your written permission, Dr. Istre will provide clinical updates to insurance carriers. These summary letters and/or chart reviews will be billed at the regular hourly rate, prorated according to time spent.

When canceling or rescheduling an appointment, I agree to notify the Center for Social Success at least 24 hours in advance. If my appointment is on a Monday, I understand I must leave a cancellation message before 12:00 p.m. on Friday afternoon. Barring unforeseen illness or injury, I agree to be responsible for full treatment charges for appointments cancelled with less than 24-hour notice and/or no-show appointments. No exceptions. I also understand that if I am late for an appointment, I will be billed for the entire scheduled time.

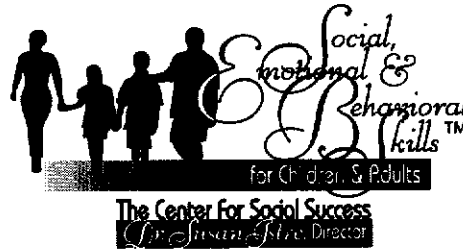
I understand that my account balance is due upon receipt. Should my account be past due and unpaid after thirty (30) days, a finance fee of 1.5% per month in addition to a late fee of \$35.00 will be assessed. I also understand that accounts past due more than sixty (60) days will receive a demand letter for payment, which if not complied with or responded to within ten (10) days may be referred to a collection agency and/or small claims court for collection and may affect my credit adversely. Charges may also be filed with the District Attorney for "theft of services".

Further more, I understand that at any time my account is delinquent all services will be discontinued and any future appointments will be cancelled until my account is brought current. All returned checks will be assessed a \$35.00 return check fee. Any account proven difficult to collect will be expected to make advance payment for any future treatment. All treatment rendered at school locations are paid on a monthly basis in advance or by automatic credit card billing. In the case of court action, subpoena, deposition, testimony or any other court related fees are required in advance via retainer. Court fees are 2.5 times that of the regular therapist rate.

I have read and fully understand my financial responsibilities to the Center for Social Success and Susan M. Istre, Ph.D., L.P.C.-S I further understand my responsibilities with regard to insurance claim submission or disputed claim negotiation.

Signature of Parent/Legal Guardian

Date



Release of Information

I authorize therapists at the Center for Social Success to release and receive information regarding evaluation and therapy, including verbal exchanges in person or on the telephone, to the doctors, therapists, schools or other professionals listed below:

1. _____
 Phone Number: _____
 Fax number: _____
 Address: _____
 Any limitations?: _____

2. _____
 Phone Number: _____
 Fax number: _____
 Address: _____
 Any limitations?: _____

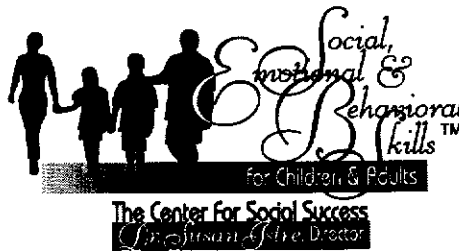
3. _____
 Phone Number: _____
 Fax number: _____
 Address: _____
 Any limitations?: _____

4. _____
 Phone Number: _____
 Fax number: _____
 Address: _____
 Any limitations?: _____

Patient's Name: (please print) _____

Patient's Parent or Guardian's Signature: _____

Date: _____



Credit Card Authorization
*****MUST BE COMPLETED*****

Upon receipt of my credit card information and my signature, I authorize the Center for Social Success to bill all charges for which I am financially responsible. I further understand that **my credit card will be charged for any outstanding balance including a 1.5% interest late charge at this time with no waiting period.** Subsequently, I authorize the Center For Social Success to bill my account balance to my credit card **twice** a month (on or around the 5th and the 19th of every month). I further understand that should my account exceed **\$300.00** at any time my credit card will automatically be charged. **I understand that my credit card will not be charged if I choose to pay for treatment in person after each appointment.** I will notify the Center For Social Success immediately of any changes to my credit card. I acknowledge that I am fully responsible for all services received and any late fees accrued at the Center for Social Success.

Credit Card Information:

(Please circle one): Visa Mastercard Discover

Account Number: _____

Expiration Date: _____ V Code: _____

 Printed Name

 Patient's Name

 Signature

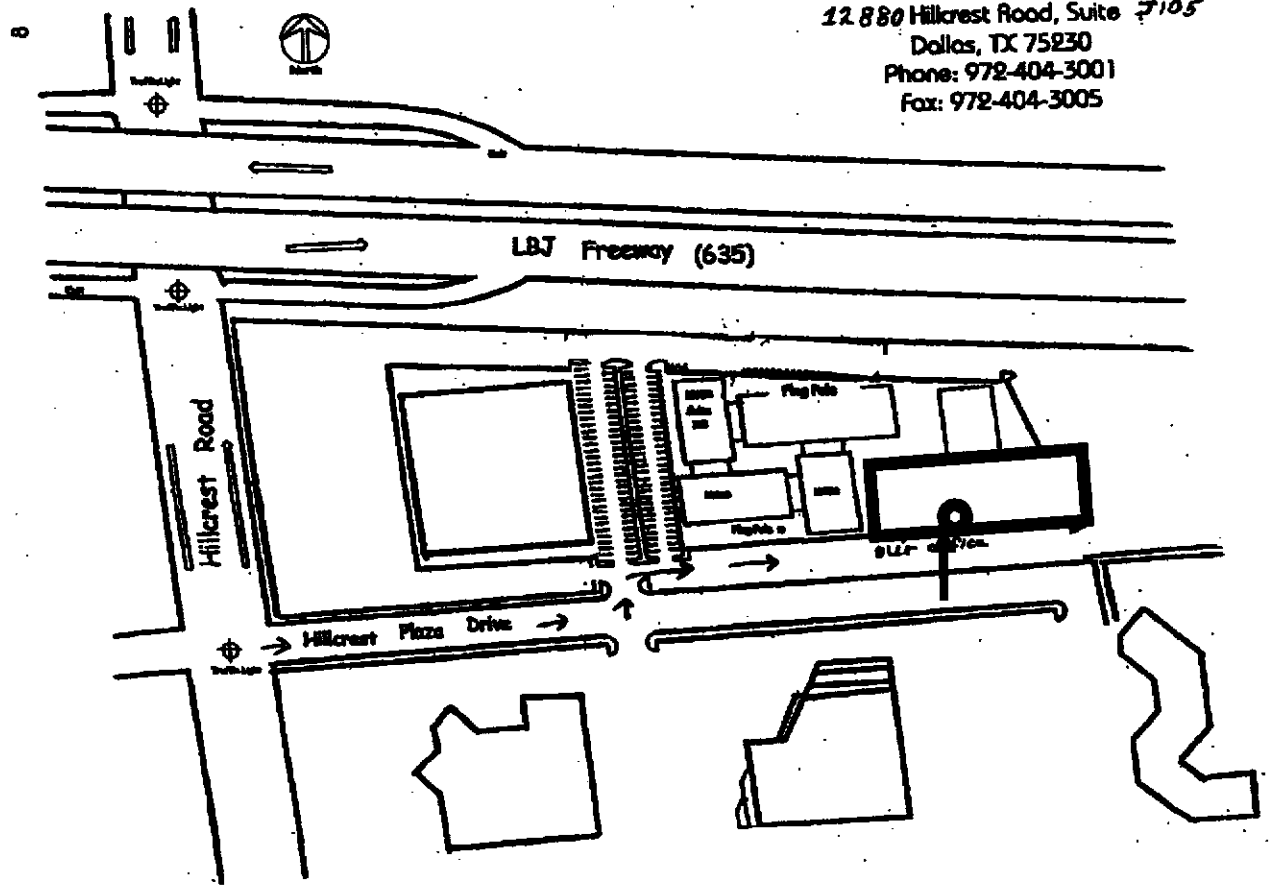
 Street Number

 Date

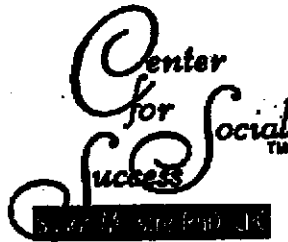
 Zip Code



12880 Hillcrest Road, Suite J105
Dallas, TX 75230
Phone: 972-404-3001
Fax: 972-404-3005



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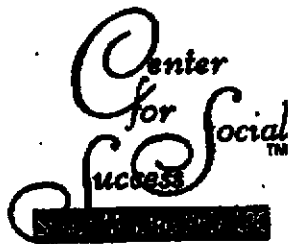
CHILD HISTORY

Family Information

Completed By: _____ Date: _____
Child's Name: _____ Nickname: _____
Birthdate: _____ Sex: _____ Age: _____ Height/Weight: _____
Home Address: _____
City: _____ Zip: _____
School (Name): _____ Grade: _____
Special Classes: _____
Father's Name: _____ Occupation: _____
Home #: () _____ Work #: () _____ Cell #: () _____
Mother's Name: _____ Occupation: _____
Home #: () _____ Work #: () _____ Cell #: () _____
Marital Status:
Married: _____ Divorced (Year): _____ Separated (Year): _____ Remarried (Year): _____
Child is Living With: Natural Parents: _____ Single Parent: _____
Parent & Step Parent: _____ Step-Parent's Name: _____
Adoptive Parents: _____ Age at Adoption: _____
Names/Ages of Siblings: _____
Number of Siblings Living in the Home: _____
Name of Primary Physician: _____
Who Referred This Child: _____
Address: _____ Phone: () _____
Reason for Referral: _____

Dr. Susan J. J. J. Director ▲ ▲ ▲ The Center for Social Success

1000 10th St. N. Suite 1000 ▲ ▲ ▲ Minneapolis, MN 55403-1000



History Information

Previous Evaluations

Please list the names of any other professionals you have consulted about this child, the date of their evaluation, their general conclusions, and the type of therapy provided. Copies of reports would be very helpful.

| Specialist | Name | Date | Diagnosis | Therapy |
|------------------------------|------|------|-----------|---------|
| Physician | | | | |
| Psychologist or Counselor | | | | |
| Educational Specialist | | | | |
| Speech | | | | |
| Other | | | | |

Note: If you would like to have any of your child's records or previous evaluation results sent to me, please sign the enclosed release of information form and send it directly to the individual who has your child's records.

Medical History

Does your child have any history of birth trauma (problems with pregnancy, delivery, prematurity, etc.)? Yes ___ No ___

Did your child walk, talk, and achieve other developmental milestones at the normal time? Yes ___ No ___ If no, please explain. _____





Please list any major medical problems: _____

Please list any medications your child is taking: _____

Has your had frequent tonsillitis, ear infections, allergies, asthma or other respiratory illness?

Yes ___ No ___

Has you child ever had head injuries, migraine headaches, seizures or epilepsy? Yes ___ No ___

Has your child ever had any nervous "tics", e.g. excessive blinking, neck stretching, etc.?

Yes ___ No ___

Family History

Please describe if you or any members of your immediate family have ever experienced the following situations/conditions:

| | Mother | Father | Child | Brother | Sister |
|---|--------|--------|-------|---------|--------|
| Problems with Aggressiveness | | | | | |
| Defiance/Oppositional Behavior | | | | | |
| Problems w/Attention, Activity & Impulse Control as a Child | | | | | |
| Academic Difficulty | | | | | |
| Learning Disabilities | | | | | |
| Frequent Job Changes | | | | | |
| Problems with Temper | | | | | |
| Mental Retardation | | | | | |
| Schizophrenia | | | | | |
| Manic Depression | | | | | |
| Alcohol/Drug Abuse | | | | | |
| Trouble with the Law | | | | | |





Child's Early Developmental & Current Social History

Did he/she have colic and cry a lot as an infant?

Does he/she get upset easily now that he/she is older?

Were there early sleep pattern difficulties?

Does he/she still have problems falling/staying asleep?

If yes, do you think this makes him/her drowsy and/or irritable all the following day?

Was he/she very cuddly as an infant?

Is he/she very friendly now that he/she is older?

Was your child persistent as an infant when he/she wanted something?

Is he/she able to accept "no" for an answer now?

Was he/she abnormally active and into things as a youngster?

Is he/she still more active than others his/her age?

Did he/she have difficulty with bowel/bladder control past three years of age?

Does he/she still ever wet or soil his/her pants during the day?

If yes, do other children make fun of this?

If yes, does your child avoid overnight stays?

Did he/she go to preschool by age four or five?

If yes, was this a good experience?

Was the teacher very sympathetic and helpful?

Was the classroom small and structured?

Was your child ever put in developmental 1st grade or held back due to social immaturity?

Do you think this was the right thing to do?

Did it help your child?

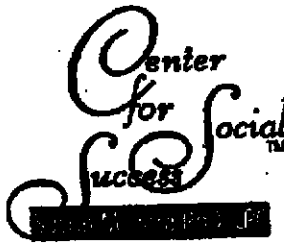
Have you had frequent complaints from your child's teachers regarding immaturity, inability to sit still and stay on task, etc?

Has your child ever been suspended from school or asked to leave school?

Does your child get along with his brothers and sisters as well as other children his/her age?

Dr. Susan Gatra, Director ▲ ▲ ▲ The Center For Social Success

1325 P St. N. ▲ 10000 ▲ 10000 ▲ 10000 ▲ 10000 ▲ 10000 ▲ 10000 ▲ 10000 ▲ 10000 ▲ 10000 ▲ 10000



If not, is it because he/she starts more fights?

Is your child able to make friends easily?

Does your child usually keep friends a long time?

Does your child currently have a "best friend"?

Has your child ever been aggressive to other children?

Is your child still aggressive?

Have you had difficulty disciplining your child?

Has your child been more difficult to discipline than his siblings?

On the average, does your child mind you:

Two or three times out of ten?

Four to six times out of ten?

More than six times out of ten?

Will he/she eventually do what you ask?

Please indicate which discipline strategies you use:

Verbal reprimands

Time-out (isolation)

Removal of privileges

Rewards

Physical punishment

Giving in to the child

Avoiding or ignoring the child

Which of the following would you advise your child to do if he/she were teased/picked on by other children:

Ignore them and walk away

Ask them to stop

Tease them back

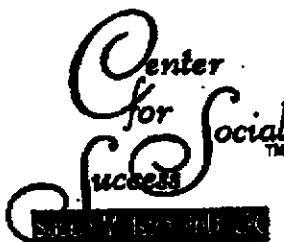
Hit them

Tell an adult

Have you ever obtained counseling to help you deal with any problem behaviors of your child?

Dr. Susan intra, Director ▲ ▲ ▲ The Center for Social Success





Did it help?

Overall, would you say your child has social skills problems?

If yes, did you or the child's other parent have similar problems as a child?

Family Stress Index

Have any of the following stressful events occurred in your family within the last twelve months?

Parents divorcing or separating?

Change(s) in people living in your household?

Family accident or illness?

Parent changing job?

Changed schools?

Family moved?

Family financial problems?

Other event that was traumatic to the child?

Do you think your child is showing any problems as a result of these changes?

If yes, do you expect them to be temporary?