Center For Social Success

Dear Client,

Welcome to the Center For Social Success (CSS)! We appreciate your choice of our therapists to address your counseling needs. We offer individual therapy for adults to address a variety of issues including social skills, anger and anxiety management, stress management, depression, organizational skills, dealing with divorce and blended family issues, parenting skills, and marital enrichment.

Included with this letter are the following forms that must be completed, signed and returned before the beginning of treatment:

- **Fee Schedule & Billing Information**
- **Client Information/History**
- **Consent Forms**
- **Statement of Professional Disclosure**
- **Statement of Financial Responsibilities**
- **Release of information**
- **Agreement Concerning Litigation Matters**
- **Credit Card Authorization Form**

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 Istre, PhD, LPC-S, Director of the Center For Social Success
Diagnosis Code: Unless previously diagnosed, a diagnosis will be determined at the initial appointment.
Service Codes: 90791-Diagnostic Interview w/Parents, 50 minutes.
Diagnostic Interview w/Child, 30-50 minutes.
90837-Individual Therapy, 60 minutes
90853-Group Therapy, 50 minutes
90846-Family Therapy without Patient Present, 50 minutes
90847-Family Therapy with Patient Present, 50 minutes

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

Susan Istre, PhD, LPC-S

Client
FEE SCHEDULE AND BILLING INFORMATION

Hourly rates for Individual and Family therapy:

Dr. Susan Istre, LPC-S, Director: $175.00
Erin Lozano, MEd, LPC-S, RPT-S Early Childhood Division Director: $150.00
Holly Fedro, LCSW, Adolescent/Adult Division Director: $150.00
Kittie Campbell, MS, LPC: $140.00
Ellen Storm Johannsen, MS, LPC: $140.00
Taylor Davis, MS, LPC-I: $130.00

Session rates for Group Therapy: $80.00

Parent and child/adolescent appointments are scheduled separately to identify issues and determine the goals of treatment.

Intern Supervision: All interns are supervised weekly by Dr. Istre and have received post graduate 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 charged at the therapist's individual rate and are vital to success. In office or phone appointments are available.

Case Management: Additional fees are charged for time spent by therapists in case management, which includes test review, phone calls to teachers and other professionals, report writing, etc.

Fees at our Shelton satellite offices: Only Shelton students are seen at this location. Payment in advance or credit card billing is required for services provided off site. All credit cards are kept on file at our LBJ office.

Litigation Fees: See separate "Agreement, Concerning Litigation Matters"

Billing and Payment Options: We accept cash, checks, Visa, MasterCard, Discover, AmEx, and pre-paid Health cards.

For your convenience, we offer automatic credit card billing. On or around 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 a zero balance bill, which you may submit to your insurance company. Authorization for automatic credit billing is maintained with your records in a secure location at the office.

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 as well as Saturday sessions 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.

Client
INFORMATION/HISTORY

Date: _____

Name: _____ **Nickname:** _____

Birthdate: _____ **Sex:** _____ **Age:** _____ **Height/Weight:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

School: _____ **Location:** _____

Occupation: _____ **Company:** _____

Home: _____ **Cell:** _____ **Work:** _____

Email: _____

Marital Status: □**Single** □**Married** □**Divorced**

Spouse: _____ **DOB:** _____ **Sex:** _____ **Age:** _____

Divorced (year): _____ **Separated (year):** _____ **Remarried (year):** _____

Occupation: _____ **Company:** _____

Home: _____ **Cell:** _____ **Work:** _____

Email: _____

How do you prefer appointment reminders? **Text:** _____ **Email:** _____ **Phone:** _____

Preferred contact information: _____

Children (Name/Age): _____

_____

Name of Primary Physician: _____

Who Referred you?: _____

Address: _____ **Phone:** _____

Reason for Referral:

_____

_____

_____

Center For Social Success

PREVIOUS EVALUATIONS

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

Specialist	Name	Date	Diagnosis	Therapy
Physician				
Psychologist				
Counselor				
Diagnostician				
Speech, OT, PT				
Other				

**Note: If you would like to have any of your 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 records.*

MEDICAL HISTORY

Please list all **medications** you are taking (name, dose, prescribing physician):

_____

_____

_____

Do you have **head injuries, migraine headaches, seizures**? Yes □ No □

Do you have nervous "**tics**" (blinking, neck stretching, etc.)? Yes □ No □

Please describe any other medical issues affecting you: _____

_____

_____

_____

_____

_____

Family History

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

	Self	Mother	Father	Brother	Sister
Problems With Temper	☐	☐	☐	☐	☐
Oppositional Defiant Behavior	☐	☐	☐	☐	☐
Problems w/ Attention, Activity & Impulse Control	☐	☐	☐	☐	☐
Asperger's/Autism	☐	☐	☐	☐	☐
Academic Difficulty	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐
Intellectual Impairment	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Bipolar	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Frequent Job Changes	☐	☐	☐	☐	☐
Alcohol/Drug Abuse	☐	☐	☐	☐	☐
Trouble with the Law	☐	☐	☐	☐	☐

Other Issue : _____ _____

ADULT ISSUES

Please circle and describe if you have **concerns** about any of the following:

Relationship Problems

Academic Concerns

Career Advice

Legal Problems

Nervous Habits

Self-Injury

Suicidal Ideations or Attempts

Eating Disorder

Aggression

Alcohol Use

Drug Use

Sexual Acting Out

Gambling

Pornography

Job Struggles

Extra Marital Affairs

Sexual Orientation

History of Abuse (physical, emotional, or sexual)

Other _____

COUNSELING

Have you ever obtained **counseling** to help you deal with any problems ?

□**Yes** □ **No** Did it help? □**Yes** □ **No**

Please identify if you are is currently seeing another counselor _____

Overall, would you say you have any **social skill issues?** □**Yes** □ **No**

If yes, did you have a similar problem as a child? □**Yes** □ **No**

Additional Information: _____

_____

PERSONAL STRESS INDEX

Have any of the following **stressful events** occurred in your family within the last 12 Months?

□ **Divorcing or separating?**

□ **Change(s) in people living in your household?**

□ **Family accident or illness?**

□ **Death of a close family member**

□ **Spouse changing jobs?**

□ **Changed schools?**

□ **Family moved?**

□ **Family Financial Problems?**

□ **Other event that was traumatic to you?**

Are you showing any problems as a result of these changes? □**Yes** □ **No**

If yes, do you expect them to be temporary? □**Yes** □ **No**

PLEASE INDICATE IFYOU HAVE ANY OTHER CONCERNS THATWERE NOT INCLUDED ON THIS FORM. USE BACK OF THIS PAGE IF MORE SPACE IS NEEDED. THANKYOU FOR PROVIDING THIS INFORMATION.

CLIENT CONSENT AND RELEASE OF LIABILITY FOR ANIMAL ASSISTED THERAPY

I understand there will be puppies and dogs at the Center For Social Success used in their Pet Assisted Therapy Program. Most of the animals are too young to be formally certified as therapy dogs. All of the animals have been screened by a veterinarian and have also received all of the vaccinations appropriate for their age, and have been prophylactically treated for parasites. They are hypoallergenic and low shedding, with sweet and loving dispositions. They are non-aggressive breeds, but often use their mouths in play and when teething.

I understand there are always some risks inherent when working with live animals. Some people may still be at risk for allergic reactions or might accidentally be scratched or bitten. There is also a small risk of the dog having an undiagnosed health condition that could be transmitted to you.

□ I **ACCEPT** the risks associated with Pet Assisted Therapy and release the Center For Social Success and it's therapists from any associated liability.

□ I **DO NOT ACCEPT** the risks associated with Pet Assisted Therapy and request that I not be allowed direct contact with the puppies and dogs at the Center For Social Success.

_____

Client's Name

_____ _____

Client Signature Date

TREATMENT CONSENT FORM

Permission for Treatment and Release of Records

I consent to the use and disclosure of my protected health information to carry out evaluation, treatment, financial activity, and health care operations provided 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.

Permission for Testing

I give permission for testing to help assess my attentional, social and/or psychological behavior. I understand that my evaluation may also involve examination of records and reports (provided by me or sent at my request). I understand that an appointment will subsequently be held in which the findings and recommendations of this assessment will be discussed.

Permission for Videotaping

I give permission for my session to be videotaped as a teaching tool to improve social skills and behavior. I understand such videotaping will be erased after use and never shared with anyone outside of the Center For Social Success

I agree that I will indemnify and hold the Center For Social Success, its therapists and interns harmless from any claims, costs or damages, including attorney's fees, that they may incur as a result of or arising out of a breach of this agreement. I understand that I must attach to this Consent the relevant portions of all court orders, including temporary orders and final decrees that concern my right or the rights of others to consent to, participate in or have access to information about the treatment of my child. 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. The only exception is if a judge issues a subpoena demanding the release of this information.

Client's Name: (please print) _____

Client'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 obtain more information 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

I also employ social workers (LMSW & LCSW) as staff therapists. Although they are not required by law to inform clients of their credentials, I will be happy to provide this information upon request.
I also employ other LPC's and I am a state approved LPC supervisor for the interns working at the Center For Social Success. I meet with interns weekly to review cases.

Susan Istre, PhD, LPC-S

Dr. Istre 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.

Client's Name: _____

Client's Signature _____ Date: _____

Client Services
STATEMENT OF FINANCIAL RESPONSIBILITY

I agree to be responsible for all charges incurred for my evaluation and treatment. 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. 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 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".

Furthermore, 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 future treatment. All treatment rendered at school locations must be paid on a monthly basis in advance or by automatic credit card billing.

Regarding court related fees see separate document entitled, AGREEMENT CONCERNING LITIGATION MATTERS.

I have read and fully understand my financial responsibilities to the Center For Social Success and Susan Istre, PhD, LPC-S. I further understand my responsibilities with regard to insurance claim submission or disputed claim negotiation.

_____ _____

Signature of Client Date

Center For Social Success

Client

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:

Name:_____

Phone Number: _____

Fax Number: _____

Address: _____

Any Limitations? _____

Name:_____

Phone Number: _____

Fax Number: _____

Address: _____

Any Limitations?_____

Name:_____

Phone Number: _____

Fax Number: _____

Address: _____

Any Limitations?_____

Client's Name: (please print) _____ Clint's Date of Birth ___/___/_____

Client's Signature: _____ Date: _____

AGREEMENT CONCERNING LITIGATION MATTERS

I understand that the Center For Social Success along with its therapists and interns, do not routinely provide expert testimony with regard to patients, their treatment, or their family situation, and any request for copies of patient records or for testimony of any kind is serious disruption of their therapeutic work and their relationship with patients. For that reason the Center For Social Success discourages any attempt to use its records or the testimony of its therapists and interns in litigation. If this is unavoidable I agree as follows:

Name(s) of patient(s):_____.

Fees for copies:

- **$20.00 per hour for labor and costs of supplies for chart copying**
- **$25.00 for the first twenty pages of copying**
- **$.50 per page thereafter**

Fees for court appearances: If I request or my attorney requests informally or by subpoena that an employee of the Center For Social Success appear in court or at deposition I agree to pay:

- $500 per hour for preparation and appearance, with a minimum of 6 hours for any appearance and a minimum of 4 hours for preparation for each employee whose appearance is requested.

- A flat fee of $500 for Dr. Istre's time supervising the preparation of any therapist or intern whose appearance is requested.

Attorney's fees: I agree to reimburse the Center For Social Success for Attorney's fees incurred by the Center For Social Success in connection with any requests for documents or an appearance in court or for deposition.

Required advance notice: I agree that I will give the Center For Social Success and any other party to the lawsuit in which copies or an appearance is requested at least 10 business days' notice of such request, regardless of whether the request is made informally or by subpoena. In addition, I authorize the Center For Social Success to notify the other parent or guardian of the request and its contents if it concerns minor child, and waive any privilege or right of confidentiality to the extent required for the Center For Social Success to give that notice.

Required confidentiality agreement: I agree that any copies or testimony from the Center For Social Success are strictly confidential, and that I will not allow any person to have access to such copies or testimony unless that person is legally entitled to such access.

Telephone Conference Request from Attorneys: The Center For Social Success cannot participate in a telephone call with just one attorney when the parents are in litigation. Therefore, if I want my attorney to have a conference call, I understand my attorney will need to set up a time that both attorneys will be able to participate. If the other attorney does not wish to participate, he/she will need to contact the Center For Social Success directly and let the Center For Social Success know in writing that they are waiving that right. Attorney conference calls are charged at $500.00 per hour. If both parties' attorneys are on the telephone, the charge is divided equally between the parties.

Required advanced payment: I agree that simultaneously with any request for copies, telephone conference, or an appearance I will pay the Center For Social Success for chart copying plus a $5000 retainer as an advance against the final appearance fee and attorney's fees agreed to above the Center For Social Success has no obligation to provide documents, participate in telephone conference, or appear unless this advanced payment is made.

Effect of failure to give notice or pay advance: I agree that if I fail to give the required notice to make the required advance then the request will deemed unreasonable and the Center For Social Success will be entitled to protection from that request as provided in the relevant court rules. I also agree that I will pay any attorney's fees incurred by the Center For Social Success in requesting such protection.

Payment of final bill: I agree to pay, within 10 days, any final bill from the Center For Social Success for copies, appearances, or attorney's fees.

Obligation to pay when copies or appearances are requested by others: I agree that if any person who has not signed an Agreement Concerning Litigation Matters, including a governmental agency, requests copies or a court or deposition appearance and fails to pay the copy, appearance fee and attorney's fees called for by the Agreement within 60 days after presentation of a final bill then I will pay all amounts due immediately upon notification of that failure to pay.

Agreement to obtain signature of other litigation parties: I agree that if there is already litigation pending that concerns my treatment or the treatment of my child I will provide the Center For Social Success copies of this Agreement Concerning Litigation Matters signed by every other party to that litigation, and that the Center For Social Success may refuse to begin treatment of me or my child until those signed copies have been provided. I agree that if litigation begins after treatment starts, I will provide the Center For Social Success copies of this Agreement Concerning Litigation Matters signed by every other party to that litigation.

Indemnity: I agree that I will indemnify and hold the Center For Social Success, its therapist and interns harmless from any claims, costs or damages, including attorney's fees, that they may incur as a result of or arising out of a request by me or my attorney to provide copies or to appear in court or at deposition, or arising out of any breach by me of this Agreement. I agree that I will pay such claims, costs or damages within 30 days after notice of the amount owed.

_____

Name of Client

_____ _____

Signature of Client Date

Center For Social Success
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 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 1th and the 15th 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 AMEX

_____

Card Number

_____ _____ _____

Expiration Date V-Code Billing Address City, State Zip Code

_____

Name on Card

_____

Signature of Card Holder

_____

Date

Client Name(s) associated with card on file:_____

Although we do not file insurance, do you need an itemized receipt to file for out of network benefits on your own? □**Yes** □ **No**

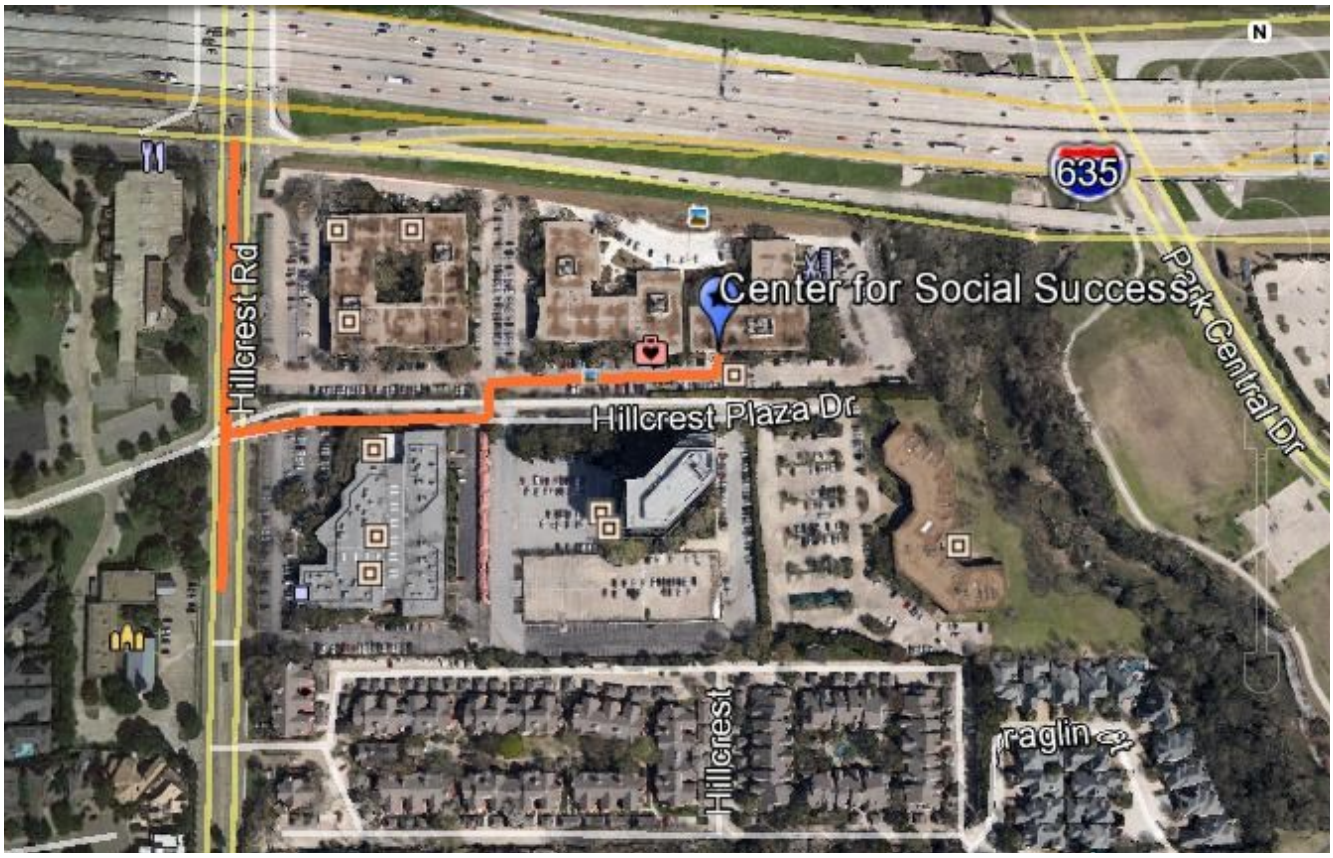
How would you like us to send your receipts?

□ **Email:** _____

□ **Mail:** _____

DIRECTIONS TO

THE CENTER FOR SOCIAL SUCCESS



Directions from 635

⇒ After turning onto Hillcrest (driving south), take a left onto Hillcrest Plaza.

⇒ Continue straight and take your first left, and then an immediate right

⇒ Follow the line of shrubs on your right until you see our outside entrance door in the second building on the left.

Directions from Hillcrest going north

⇒ Take a right onto Hillcrest Plaza

⇒ Continue straight and take your first left, and then an immediate right

⇒ Follow the line of shrubs on your right until you see our outside entrance door in the second building on the left.