Kellie Curreri, PhD, LSSP, LP
Life Rules Mental Wellness, LLC
liferulesmentalwellness.com 972.333.2912

Welcome to Life Rules Mental Wellness, LLC

I appreciate your choice to trust Life Rules Mental Wellness, LLC (LRMW) with your mental health services, and I am eager to work with you and your child. This Client Information packet needs to be downloaded, printed, completed, and returned. I will review the forms at the intake appointment. If you are unable to download and print the packet prior to your intake appointment, please plan to arrive at this appointment at least 20 minutes early to complete them.

Notice of Privacy Policies

1) The protected health information (PHI) about the client is maintained in a confidential manner as is required by state and federal laws. The client's PHI may be used and/or disclosed with your consent for treatment, payment, and health care operations purposes.

2) The client's PHI may be used and/or disclosed beyond the purposes of treatment, payment, and health care operations with your proper prior authorization. Proper authorization is defined as the adult client's or parent's/legal guardian's written consent for the release of confidential PHI. Authorization or written consent to release confidential information is also required prior to releasing treatment summaries, which provide an overview of the client's progress based the client's treatment plan and a status update of counseling sessions attended to that point. Treatment summaries are different from psychotherapy notes, which document and analyze the content of the confidential conversations between the client (i.e., individual, family, and/or group) and therapist and are also maintained in a confidential manner. These notes are given a greater degree of protection than PHI and are not released to the adult client or client's parent/legal guardian.

3) The client's PHI may be used and/or disclosed without prior authorization or consent, also known as *the limits of confidentiality*, when:
   a) **Child Abuse/Neglect** - we have cause to suspect that a child or adolescent has been or may be abused, neglected, or sexually abused. We must make a report within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
   b) **Adult Domestic Abuse** – we have cause to suspect that an elderly or disabled person is in a state of abuse, neglect, or exploitation. We must immediately make a report to the Department of Protective and Regulatory Services.
   c) **TX Behavioral Health Executive Council (BHEC) Oversight** – If a complaint is filed against a licensed psychologist or licensed specialist in school psychology ("licensee") with the BHEC, the Council has the authority to subpoena confidential mental health information from us relevant to that complaint.
   d) **Judicial or Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your minor child's or your diagnosis and treatment and the records thereof, such information is privileged under state law. We will not release information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
   e) **Serious Threat to Health and Safety** – If the therapist determines that there is the probability of imminent physical injury by the client to themself or others, or there is a probability of immediate mental or emotional injury to the client, we may disclose relevant confidential mental health information to their treating medical practitioner or law enforcement agency.
   f) **Worker's Compensation** – If the client files a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

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4) Client's Rights:

a) **Right to Request Restrictions** – The client or parent/legal guardian has the right to *request* restrictions on certain uses and disclosures of PHI about the client. *However*, we are not obligated to agree to such requested restriction.

b) **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at an alternative location(s). For example, you may not want a family member to know that your child or you are being seen at this office. Upon your request, your bills may be sent to another address that you provide.

c) **Right to Inspect and Copy** – The client or parent/legal guardian has the right to inspect and/or obtain a copy of PHI and psychotherapy or counseling notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access to PHI may be denied under certain circumstances, and at your request, we will discuss with you the basis of and process for a denial of your request.

d) **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request, and at your request, we will discuss with you the basis of and process for a denial of your request.

e) **Right to Accounting** – Generally, you have the right to receive an overview of disclosures of your PHI for which you have not provided consent or authorization.

f) **Right to a Paper Copy** – You have the right to obtain a paper copy of the disclosure from me upon request, even if you agreed to receive the disclosure electronically.

5) Therapists Duties:

a) Maintain the confidentiality of PHI and to provide you with notice of our legal duties and confidential practices for PHI.

b) Reserve the right to revise or update our confidentiality policies and practices outlined in this notice. Unless you are notified of such revisions or updates, we are required to abide by the terms outlined and presently in effect.

c) Post a notice of revisions or updates to LRMW policies and/or practices on liferulesmentalwellness.com. We may also choose to provide you with notice by mail at the address provided to us.

6) Complaints:

a) If you are concerned that your confidentiality rights have been violated or you disagree with a decision made about access to your records, you may contact:

i) Dr. Kellie Curreri, Owner and CEO of Life Rules Mental Wellness, LLC at 972.333.2912 or kcurreri@liferulesmentalwellness.com

ii) NOTICE TO CLIENTS The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information. Adopted to be effective: September 1, 2020

iii) Mail or email your complaint and supporting documentation to:

Texas Behavioral Health Executive Council
Attn: Enforcement Division
333 Guadalupe St., Suite 3-900
Austin, TX 78701
enforcement@bhec.texas.gov

Adult Client and/or Legal Guardian(s) Initials: _____

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Client Information Form

Client First Name: _____ **Client Last Name:** _____

Client's D.O.B.: _____ **Age:** _____ **Client's Address:** _____

Client's Phone: _____ **Voicemail &/or Text Message Permitted Yes:**_____**No:**_____

Client's Email Address: _____ **Preferred Communication:** _____

Client's School/Employer: _____ **Client's Grade/Year:**_____

Parent(s)/Legal Guardian Name: _____ **Relationship:** _____

Parent/Legal Guardian Address: _____

Email Address: _____ **Phone:** _____

Client's Emergency Contact: _____
Name **Relationship** **Phone**

If the client's parents are divorced/separated/not living together, please attest to your legal right to consent to the client's mental health services by Life Rules Mental Wellness, LLC and that the non-custodial parent is aware that the client is receiving these services or provide copy of a court order that terminates the non-custodial parent's decision-making authority for medical/mental health treatment.

Non-Custodial Parent: _____
Name **Relationship** **Phone/Email**

LRMW Service(s) Paid By: _____
Name **Relationship** **Phone**

Non-Custodial Parent's Address (if different): _____

Non-Custodial Parent's Email Address: _____

I hereby give the Life Rules Mental Wellness, LLC and their staff permission to file any and exchange any necessary protected health information (PHI) necessary to receive payment for services performed.

_____ _____
Adult Client or Parent/Legal Guardian Signature **Date**

_____ _____
Adult Client or Parent/Legal Guardian Signature **Date**

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PAYMENT POLICY

FEES: All fees are private pay or "out of pocket." An invoice for reimbursement by your insurance is available upon request for all completed and paid sessions.

The standard hourly fee is **$200** for an individual counseling session, **$100** for a 30- minute session, and **$75** for less than a 30-minute session. Consultations have the same fee structure as a scheduled session (see above). The parent/legal guardian who initiates the consultation is financially responsible for payment at the time of service even if not the person responsible for recurring sessions.

The standard fee for a psychological evaluation is **$3000**, which includes all clinical interviews, records review, test administrations, test scoring, and report writing. The session to review the findings with the client and/or parent/legal guardian(s) has a separate fee based on the fee structure for a scheduled session (see above). Should the scope of the psychological evaluation need to go beyond the customary scope, there may be an additional fee, which will be discussed prior to any change in the original fee. Requested consultations for the findings to be reviewed with other professionals (e.g., physician, school staff, etc.) will incur a session fee based on fee structure described above. The parent/legal guardian who initiates the professional consultation is financially responsible for payment at the time of service even if not the person responsible for the psychological evaluation.

The standard fee for a threat assessment is **$750**, which includes all clinical interviews, records review, and report writing. The session to review the findings with the client and/or parent/legal guardian(s) has a separate fee based on the fee structure for a scheduled session (see above). Requested consultations for the findings to be reviewed with other professionals (e.g., physician, school staff, etc.) will incur a session fee based on fee structure described above. The parent/legal guardian who initiates the professional consultation is financially responsible for payment at the time of service even if not the person responsible for the psychological evaluation.

A charge of **$200** per hour or the prorated fee structure described above will be billed for other professional services you may request, such as a written therapy or treatment summaries, attendance at a school-based meeting (by phone, virtual platform, or in person), telephone conversations that last longer than 10 minutes, preparation of records, or the time required to perform any other clerical/administrative service. **A minimum fee of $50 is charged for copies of complete records or reports and a minimum of 2 weeks' notice is required.**

MISSED APPOINTMENTS: Once your child's or your appointment is scheduled, you will be expected to keep that appointment and pay your therapist's full session rate or a maximum of an $100 cancellation fee unless you provide 48-hour advance notice of cancellation except for extreme emergencies (accidents, emergency Illnesses, etc.). If you arrive more than 15 minutes late for an appointment, the session will be considered missed unless other arrangements are worked out with the therapist. This late cancellation fee will **not** be waived for work conflicts. Frequent cancellations and rescheduling may result in termination and referral by your counselor to alternative support and will be discussed by phone or in person before this occurs. **The parent/legal guardian (guarantor) will be held legally responsible for any fees incurred, including cancellation fees.**

COURT RELATED FEES: I have no family court or forensic counseling or forensic evaluation experience. If you become involved in litigation that requires my participation including but not limited to divorce, custody disputes, cases CPS cases, or criminal activity, I charge **$200 per hour** for preparation, paperwork and travel due to the complexity and difficulty of any legal proceedings. If court appearances are required, clients will be charged **$1000 for a half day and $2000 for an entire day.** Also, **a $1500 retainer** will be required up front if a subpoena is issued or court appearances are requested.

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PAYMENT METHODS: The financial guarantor will be expected to pay for each appointment/session at the start of the session, unless we agree otherwise. Payment schedules for other professional services will be agreed to at the time these services are requested. Payment can be made in the form of cash, credit card, or flexible spending account card. If you prefer to pay by credit card, there will be a **$2** processing fee added to amounts up to **$199**, and a **$3** processing fee for amounts over **$200**. ***Sessions will be discontinued if an outstanding balance develops without the establishment of payment arrangements, and an interest rate of 20% will be added to all outstanding balances. Checks are not accepted.*** If an unpaid balance occurs, this can be turned over to a credit recovery service which may report medical collections to the standard credit reporting agencies, adversely affecting a client(s)' credit score.

Adult Client or Parent/Legal Guardian Signature **Date**

Adult Client or Parent/Legal Guardian Signature **Date**

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INFORMED CONSENT

THERAPY SERVICES:

Therapy has shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, healthier relationships, and resolutions of specific problems. However, therapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness, and helplessness. Therapy often requires discussing unpleasant experiences and events of the client's life. It requires a very active and consistent effort on the part of both the client and therapist. Although everyone's progress varies, to make the most significant progress, the client will need to use the new tools and skills both during and outside of our sessions that are developed in session. If the client decides to proceed with therapy, a standard **session lasts 50 minutes** in duration. Some sessions may be longer or shorter depending on the client's specific needs and treatment goals.

The first session will involve an assessment of the client's needs based on the information you provide in the Client Information packet and during the initial session. By the end of the assessment, the client and therapist will be able to develop an initial treatment plan to follow. The client should consider this information along with their own comfort level working with their therapist. Ask any questions and/or raise any concerns about the therapy process - no concern is too small if it affects the therapeutic relationship. If at any time the client feels that the issues discussed have not been satisfactorily resolved, please feel free to contact the owner and CEO of Life Rules Mental Wellness, LLC or ask for a referral.

THERAPY CONFIDENTIALITY

Both the law and professional standards of ethics require that clients' treatment records are maintained in a confidential manner. The rights of confidentiality extend only to the client, even when the client is a minor. In general, the confidentiality of all communications between a client and a therapist is protected, and a therapist can only release information about what occurs during session to others with written permission. However, there are several exceptions, ranging from certain legal proceedings to suspicions of harm to people from vulnerable populations. If a staff member believes that a client presents a danger to themselves or to someone else, the staff member is required to take protective action. If a **child, elderly person, or disabled person is suspected of being abused or neglected,** a report must be filed with the appropriate state agency. If the minor client is considered a danger to themselves or others, their parent/legal guardian will be notified or the local authorities. If the adult client's behavior and/or communication reveals that the client is a danger to themselves, then their emergency contact(s) or legal authorities will be notified.

Understand that confidentiality is not the same as statutory privilege. If a legal subpoena is Issued by the court or if you give permission for exchange of information for insurance purposes, details regarding sessions may be disclosed. It is the policy of Life Rules Mental Wellness, LLC to make every effort to contact you first should this occur. Please refer to the disclaimers on our Release of Confidential Information form.

To ensure that you receive the highest quality, ethical care, commonly occurring client situations are discussed during consultations with other mental health professionals. In these consultations, identifying information is **not** disclosed. The consultants are, of course, also legally bound to keep the information confidential. Unless I determine it necessary for your child's overall progress, I will not disclose these consultations.

CONFIDENTIALITY EXCEPTIONS

- Please note that anyone attending group and/or family sessions has access to the records of that session.
- **PARENTS/LEGAL GUARDIANS OF MINORS:** If the client is a child or adolescent and is engaging in reckless behavior or persistent substance use, the therapist and client will discuss the need to inform the parent about these challenging behaviors. The child/adolescent client will then be given the opportunity to inform their parent/legal guardian during the therapy session about the behaviors that the therapist considers unsafe. Please understand that the client's confidentiality will not be violated over defiant or rebellious behavior/decision-making that is not life threatening. We will make every effort to create a safe environment within the session and encourage the client to be open and honest with their parent/legal guardian as transparency is a recognized

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dynamic of a healthy relationship. If a parent/legal guardian is concerned about our keeping of confidentiality, we encourage the family to schedule a family session to discuss this matter.

- **PARENT CONSULTATIONS**: Remember, the rights of confidentiality extend only to the child as the client. If you share information during a parent consultation that would impact your child's treatment or if the client is present, please know that either parent/legal guardian has access to the child's records and anything said by a parent would not be considered confidential during a family session or parent consultation since the parent/legal guardian is not a client. We will discuss your questions and/or concerns about the limits and requirements of confidentiality as they arise. This overview of confidentiality within the context of parent communication and how confidence is upheld or limited is intended to inform you as the client begins therapy at LRMW. Since the laws that govern confidentiality are multifaceted and complex, we encourage you to seek legal advice if you need to make decisions with legal implications about any communication you share or may share about your child's/adolescent's treatment.

I **acknowledge that if** I **am signing on behalf of my minor child,** I **am their legal guardian and have the legal power to give medical/psychological consent.** If I am divorced, I have been informed that a copy of my divorce decree that documents my legal authority to consent to my child's medical/psychological treatment is required for any follow up visits. I also am aware of this practice's philosophy that compelling a therapist to reveal records or appear in court is rarely therapeutic for children participating in therapy because it destroys their therapeutic relationship and experience of the therapy session as a safe place.

Adult Client or Parent/Legal Guardian Signature _____ **Date** _____

Adult Client or Parent/Legal Guardian Signature _____ **Date** _____

ELECTRONIC COMMUNICATION: It Is against HIPAA standards for us to use unencrypted electronic means of communication (i.e., text or email) to contact the client or exchange information about the client. If you choose to use either electronic forms of communication, your therapist will not reveal or respond in any manner with therapeutic protected health information (PHI). Also, please make sure that you keep records of your appointment schedule given that last minute texts or emails to verify date and time of a scheduled appointment may result in your not keeping an appointment, which could incur a late cancellation fee. I recognize the occasional need for you to send an urgent, brief text or email message but need to make you aware that information communicated this way is NOT protected. ***If your therapist does not respond, you will need to follow up with a phone call and leave a message. It is your responsibility to confirm their receipt of any information sent by text or email.***

If you want your therapist to respond to your urgent text or email message, please initial below.

Adult Client/Parent/Legal Guardian Initial: _____

SEEING MY CHILD'S RECORDS: As your child's parent/legal guardian, you are generally entitled to receive a copy of their records, with a written request. The same is true if you are an adult client. Because these are records that are written for the purpose of clinical treatment, they can be misinterpreted, confusing, and/or upsetting. Most often a treatment summary is provided. If you wish to see the client's records, it is recommended that you review them in your therapist's presence so that we can discuss the content.

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You will be charged a $50 fee for the preparation of your records request up to the first hour, and a $150 hourly fee for any additional preparation time required to complete your records request. Additionally, a records request requires a minimum of one week's notice and a maximum of fifteen days. **If for any reason your child's therapist becomes unavailable due to illness, injury, or death, please contact Dr. Kellie Curreri, LP, LSSP at 972-333-2912. If she is not available, please call the reception at 469-626-5100.** Dr. Curreri will become custodian of all files that have not been destroyed. Files are destroyed in compliance with state and federal law and shall be maintained for a minimum of 7 years after the date of termination of services with the client or five years after a client reaches the age of majority (18 years), whichever is greater.

If you request records that include standardized evaluation protocols, which are not included in client's evaluation/test data and are copy righted materials, we will not be able to copy test protocols. We can review the client's responses to specific items, scoring of specific sections, and/or other aspects of the protocol that produced the findings recorded in the evaluation report.

Psychotherapy notes are not provided as part of a records request as they are separated from the rest of the client's medical record and are for the therapist's use in treatment solely to document and analyze the content of a conversation during a private therapy session.

Adult Client/Parent/Legal Guardian Initial: _____

CONTACTING YOUR THERAPIST: Our main number is **972-333-2912.** It is also listed on the website, liferulesmentalwellness.com. Every effort will be made to return your call by the end of the next business day with the exception of weekends and holidays and otherwise noted on your therapist's outgoing message. **In emergencies, call 911 or go to an emergency room. You can leave a message *after* contacting 911, your physician, the emergency room of your choice, or a licensed mental health facility.**

Adult Client/Parent/Legal Guardian Initial: _____

GIFTS: Please understand due to ethical standards set forth by the state of Texas, it is our policy not to receive gifts valued at above $50.00.

Adult Client/Parent/Legal Guardian Initial: _____

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THERAPY CONTRACT

I, the client or parent/legal guardian (signed below), affirm the accuracy of the personal information provided herein, and have read the information above and agree to the conditions set forth therein. **It is vital that the client initial their agreement with each statement if capable of understanding these agreements.**

I hereby agree to the following conditions (please initial each statement if you agree):

_____ I am committed to changing my life by making positive choices.

_____ I will keep the appointment time or will call to cancel 48 hours in advance with a legitimate excuse.

_____ I will fulfill the counseling homework assignments.

_____ I will begin to build a support network outside of the session to sustain personal growth.

_____ I understand that confidentiality cannot be guaranteed as indicated in the previous pages including limits regarding harm to self or others, supervision and consultation, legal issues, and electronic communication.

_____ I understand that early termination of therapy is required in writing, and it is most beneficial to exit therapy with a closure session.

_____ I understand that if I am the financial guarantor of the client, I am responsible for any fees the client may incur. If I am an adult client, I understand that I am ultimately responsible for any fees.

_____ I also acknowledge receipt of **Notice of Privacy Policies and Life Rules Mental Wellness, LLC Informed Consent.**

Client Signature	Date
Parent/Legal Guardian Signature	Date
Therapist Signature	Date

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CLIENT INTAKE THERAPY QUESTIONNAIRE

Referral & Behavioral Information:

What is your current primary concern about the client's functioning? _____

_____

_____

Please circle all symptoms the client experienced during the past 2 weeks

Decreased Energy	Panic Attacks	Intrusive/Negative Thoughts
Guilt	Excessive Worry	Concentration Problems
Sleep problems	Anxiousness	Obsessions/Compulsions
Hopelessness	Worthlessness	Relational Difficulties/Conflicts
Eating Problems	Impulsivity	Thoughts of Death/Suicide
Tearfulness	Irritability	Inappropriate anger
Mania	Delusions/Hallucinations	Self-Injurious Behavior
Dissociative States	Increased Alcohol Use	Use of Illegal Substances
Hyperactivity	Depressed Mood	

Other Symptoms: _____

_____

Approximately when did these symptoms begin, including those checked? _____

Has the client been diagnosed with any ongoing condition/disorder? Yes/No _____ If so, please explain and include dates of diagnoses. _____

_____

What do you like and enjoy about the client, including their strengths? Consider their talents, personality traits, academic/school performance, work performance, following directions, social behavior, etc.

_____

_____

_____

What are the client's interests, particularly lifelong interests, hobbies, passions? _____

_____

_____

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List symptoms or challenges the client is currently experiencing that may be interfering with aspects of their daily life, including family relationships, friendships, work, and/or school: _____

_____

Approximately when did these symptoms begin? _____

What has been the course of the client's symptoms (i.e., getting better, worse, or staying the same) in the last 3 months? Explain. _____

_____

_____

Has the client experienced similar symptoms before? Yes/No _____ If so, please explain. _____

_____

_____

What has the client tried that improved or worsened their symptoms? _____

_____

List symptoms or challenges, if any, the client previously experienced that interfered with aspects of their daily life, including family relationships, friendships, work, and/or school: _____

_____

_____

Approximately when did these symptoms end? _____

What stressful life events have occurred within the last 3 months, if any (e.g., death, major move/relocation, end of a relationship/friendship, family change, etc.)? _____

_____

_____

Has the client ever used an illegal substance or illegally used a legal substance? Yes/No _____ If so, please share which substance was used and for how long. _____

_____

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What (if any) psychotropic medications (prescription drugs that affect one's mental state and behavior) is the client taking or has been prescribed? _____

_____

What (if any) supplements/over-the-counter medications is the client currently taking (i.e., vitamins, gummies, etc.)?_____

Date of the client's last physical checkup? _____

Has the client been hospitalized for a medical or psychiatric need(s) or placed in a partial hospitalization program (PHP) and/or intensive outpatient program (IOP)? Yes/No_____ If yes, please explain (i.e., when, why, where, etc.). _____

_____

_____

Have other health professionals (e.g., pediatrician, psychiatrist, psychologist, counselor, etc.) treated the client for their symptoms? Yes/No _____ If so, please explain._____

_____

List the dates and type(s) of intervention/treatment (i.e., speech therapy, occupational therapy, counseling, tutoring, etc.) services received by the client as well as needs these services addressed: _____

_____

_____

_____

Has the client ever been the victim of abuse, neglect, a traumatic event (child or domestic physical/verbal/sexual abuse, crime victim, bullying, loss of a loved one, homelessness, food insecurity, etc.), or any significant event that impacted the way the client views themselves or their world? Yes/No _____ If so, please explain. _____

_____

_____

_____

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Briefly describe the client's relationships with members of their family members (close, distant, conflicted): _____

Briefly describe the client's history with initiating, making, and keeping friendships: _____

Briefly describe any specific talents and/or skills, if any, the client showed during childhood as a toddler as well as during preschool and elementary school years: _____

Does the client have a supportive and/or spiritual community? Yes/No _____ Explain. _____

Briefly describe the client's relationships with members of their family members (close, distant, conflicted): _____

Briefly describe the client's current significant relationships (friends, mentors, and/or romantic partners):

For older clients, have you been married or lived with someone for more than a year? Explain. _____

Has the client ever been incarcerated or placed on probation? Yes/No _____ Explain. _____

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School Information:

Did the client attend daycare, preschool, etc.? Yes/No _____ If yes, please provide general ages/dates. _____

_____

Is the client currently enrolled in school (e.g., public/private/home school or college)? Yes/No _____

Please explain the client's school functioning, including their academic, behavioral, social, and discipline history

_____

_____

_____

_____

Did/does the client have school-based interventions through a Section 504 plan or Individual Education Program (IEP – Special Education)? 504 Plan-Yes/No _____IEP-Yes/No_____ If yes, please provide grade level(s)/dates during which the services were implemented and the condition(s) for which the services were provided. The evaluator will need a copy of the plan(s) and evaluation(s) if available. _____

_____

_____

Please share any other information you want me to know before we begin. _____

_____

_____

_____

Patient seen with: Mother _____ Father _____ Other _____

Diagnostic Impressions: _____

_____

_____

Initial Treatment Plans: _____

_____

_____