Monica Urbaniak, LMFT-S
6750 Hillcrest Plaza Drive, Suite 304 • Dallas, TX 75230 • 214-347-9765

NEW CLIENT INFORMATION Date: _____

Name: _____ Pronouns: _____

Date of birth: _____ Age: _____ Ethnicity/Race: _____

Current gender: _____ Gender or sex assigned at birth (optional): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ ❒Cell ❒Hm ❒Wk Email: _____

Consent to leave a message or send mail/email: ❒Yes ❒No

Special instructions for messages: _____

Emergency contact name: _____ Relationship: _____

Emergency contact phone #: _____

Current status: ❒ Never married ❒ Currently married/partnered ❒ Separated ❒ Divorced ❒ Widowed

Total number of marriages/partnerships and duration: _____

Sexual orientation (optional): ❒ Bisexual ❒ Gay ❒ Lesbian ❒ Straight ❒ Self-identify _____

Number and ages of children: _____

Occupation: _____

Referral source: _____

List any health concerns and treating physician: _____

_____

List any psychological diagnosis and who made the diagnosis: _____

_____

List any medications (with dosages), reason prescribed, and the prescribing physician's name: _____

_____

_____

_____

Psychiatrist: _____ Prior hospitalizations for mental health concerns: ❒Yes ❒No

If yes, when/where/reason/duration of stay: _____

What is your main concern currently? _____

_____

_____

Have you ever sought counseling before (includes family, couples, etc., for any reason)? ❒Yes ❒No If yes, where/with whom? _____

_____

Days and times available for counseling: _____

Informed Consent

Welcome to the independent practice of Monica Urbaniak, Licensed Marriage and Family Therapist Supervisor. Services provided include, but are not limited to: individual therapy, couples/relational therapy, group therapy, and family therapy. Thank you for trusting me with your care. Please carefully read the information in this packet and please do not hesitate to ask any questions you may have. You will be asked to sign a "Consent to Treatment" form once you have read and understood the information in this packet and prior to beginning treatment.

Therapy Services

Therapy is a collaborative partnership between the client and therapist. Therapeutic work will be directed toward mutually determined goals. To achieve the best results possible, your active participation and commitment are required, and it will be important for you to explore your feelings and thoughts, as well as, try new approaches. Therapeutic work is a personal exploration and may lead to changes in your perspectives, behaviors and relationships. Together, we will work toward the best possible outcomes for you. While benefits are expected from this work, no specific results can be guaranteed. Please discuss any concerns or confusion you might have about treatment with me. If I should determine, following the intake appointment or any time during the course of treatment, that a referral is appropriate in order to address your specific needs, one will be provided, and it will be your responsibility to contact and engage those resources. I provide services to adults and adolescents. I will only see children as part of family therapy sessions. I am happy to provide referrals for therapists who specialize in working with children. If you or your minor child are currently under the care of another therapist or a psychiatrist, a release of information will need to be signed to determine the best plan for care.

Please note: If you are seeking counseling for your minor child and are divorced, separated, or currently involved in any legal proceedings, you must submit a hard copy of your current divorce decree and any additional orders currently in effect that supplement the decree. In so doing, you are documenting that you have the legal right to seek counseling for your child. Additionally, if you become involved in a divorce or custody dispute, please understand that I will not provide evaluation or expert testimony in court. In the event disclosure of your records or my testimony is requested or required, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged at the time of the request or service of subpoena with a minimum of 4 hours billed (current rate is $300 per hour). Additionally, you are responsible for time spent in travel for local hearings, time spent in review, preparation and consultation, travel expenses for events outside of Dallas, and any on-call or waiting time. Payment is required 72 hours prior to when the services are to be rendered and any additional fees will be billed, and payment must be made, within 72 hours after service is delivered. You are also responsible for any legal fees I may incur related to your case (litigation, representation, lack of payment, etc.). A deposit may be required for anticipated court appearances and preparation.

Scheduling and Fees

Therapy sessions, intakes and consultations are by appointment only and will typically last 50 minutes. Payment is due at the time services are rendered and billed at a rate of $175 per session (individual) and $200 per session (couple/relational/family). Sessions are typically scheduled for once a week but may vary in frequency or duration depending on the specific treatment plan or the type of session. Cash, checks, and credit cards as accepted. For your convenience, a credit card may be kept on file. Your session time is reserved just for you. Late arrivals will not extend the scheduled session or alter the fee. Any cancellations must be made with at least 24 hours' advance notification by calling 214-347-9765. Not attending a scheduled appointment or cancelling an appointment with less than 24 hours' notice will result in the full session fee and will be charged to the credit card on file. For any missed or cancelled appointments, it is your responsibility to reschedule. Any outstanding balances must be paid before any additional sessions will be scheduled. Multiple missed appointments or late cancellations may result in termination of services.

Clients arriving for services who appear to be under the influence of substances which may cause impairment (alcohol, prescription or illegal drugs, etc.) will not be seen and will need to secure safe transportation from the office. In support of the health and well-being of clients and staff, no smoking, e-cigarettes or tobacco use is allowable. Weapons of any kind are prohibited. For the health and safety of all, only service animals trained to provide assistance to an individual with a disability will be permitted.

Crisis Care, Communication Between Sessions, & Professional Relationship

Please note that I do not provide 24-hour crisis or emergency therapy services. If you are experiencing a mental health emergency, please call 911, go to your nearest emergency room, or call one of the following hotlines: Suicide and Crisis Center of North Texas (214-828-1000) or the National Suicide Prevention Lifeline (800-273-8255).

You may contact me via phone between sessions for scheduling and minor, non-emergency issues. Please understand that I may be in session or out of the office and may not be able to return your call immediately. I do my best to try to ensure that calls are returned by the end of the next business day. Phone sessions may be set up occasionally under certain conditions. Phone sessions will result in a full fee for a counseling session or per quarter hour.

Please note that email is not a secure form of confidential communication. Email must be limited to scheduling and should not contain private, sensitive and/or therapeutic issues or concerns. Additionally, I will not accept friend or contact requests from any clients, past or present, on any social media sites. Any requests to engage using social media will be denied to ensure privacy. To honor the integrity of the relationship and to protect both therapist and client, I strictly adhere to the code of ethics set forth by my licensing board. Although therapy sessions may be very personal, the relationship is a professional rather than social one. Additionally, bartering or trading services is not allowed.

Confidentiality and Records

Your privacy and confidentiality are highly valued. Our communications over the course of therapy become part of your protected health information, recorded in your client file, which will remain confidential and securely stored. You will be notified when disclosure of your records is required by law. Records will be destroyed five years after the termination of services delivered. Please refer to the notice of privacy practices in this packet.
Please be aware of the following exceptions to confidentiality:

- You provide consent to release your records or share information regarding your treatment.
- You are at risk of imminent serious harm to yourself or others. (In which case your therapist will contact the proper authorities. Medical and/or law enforcement personnel may be notified with or without your consent)
- You disclose known or suspected abuse, neglect or exploitation of a child (17 and under), a person with a disability or an elderly person (65 and older).
- You disclose sexual misconduct of a physician or therapist.
- A court order is received to disclose information.
- You file a complaint with a licensing board or in cases of a malpractice suit (records will be released to the board and to legal counsel).

In the case of my death or incapacity, I have made provisions for another mental health provider to take possession of all client records. In such a situation, you can request copies from the designated provider or request that copies of records be delivered to a therapist of your choosing.

Client Rights and Termination of Services

I take the privilege of serving clients very seriously and I strive to provide a safe environment for clients and staff alike. Some clients may require only a few sessions to achieve their goals, while others may require months or sometimes even years of treatment. We will collaborate on a plan for treatment specific to your needs and goals. You have the right to

terminate therapy at any time. In such cases a termination session is highly encouraged. In circumstances where I have reason to believe service to a client is no longer a need, not in the best interest of the client and/or may potentially jeopardize the safety and well-being of other clients and staff, I may refuse to serve or terminate services. Any behavior or language that is seen as threatening, violent or abusive will result in the refusal or termination of services and the potential involvement of appropriate authorities. Should you ever have any concerns about your treatment, please notify me immediately. I will make every effort to hear any concerns you have and to seek solutions collaboratively with you. If you believe that I have not behaved in an ethical or professional manner, you may report your concerns to the Texas State Board of Examiners of Marriage and Family Therapists, Texas Department of State Health Services, Mail Code 1982, PO Box 149347, Austin, TX 78714.

Consent to Treatment

I, _____, have reviewed the following and my initials by each indicate that I understand, agree to, and will comply with each requirement:

_____ I have read and received a copy of the Informed Consent, the Notice of Privacy Practices, and have had the opportunity to discuss the information found therein with my therapist/my child's therapist. I know that I can ask about any of this information at any time with my therapist/my child's therapist throughout the course of treatment. I understand that I have the right to withdraw my consent to treatment at any time, for any reason. However, I will make every effort to discuss my concerns before ending therapy.

_____ I understand the limits to confidentiality as outlined in the Informed Consent and the Notice of Privacy Practices.

_____ I understand no specific promises have been made to me about the results of treatment, the effectiveness of the procedures used, or the number of sessions necessary for therapy to be effective. I understand the benefits and risks of therapy.

_____ I understand the structure around scheduling, appointments, and crisis needs.

_____ I agree to pay for services at a rate of $175 per session (individual) or $200 per session (couple/relational/family). I understand that cancellations not made at least 24 hours prior to my appointment time, or appointments missed without any cancellation will be charged the full fee. I agree that my credit card on file will be charged for those sessions.

_____ I agree to act according to the points covered in the Informed Consent. I hereby agree to enter into therapy/have my child enter into therapy with Monica Urbaniak, LMFT-S, and to cooperate to the best of my ability, as shown by my signature below.

_____ _____

Client or Parent/Guardian Signature Date

I, Monica Urbaniak, LMFT-S, have discussed the issues above with the client (and/or their parent/guardian/other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent. I agree to enter into therapy with the client, as shown by my signature here.

_____ _____

Therapist signature Date

CREDIT CARD AUTHORIZATION FORM

Scheduling and Fees

I, _____, have reviewed the following and my initials by each indicate that I understand and agree to the following terms:

_____Therapy sessions are billed at a rate of $175 per session (individual) or $200 per session (couple/relational/family). Sessions extending beyond the typical 50 minutes may incur additional fees.

_____Phone sessions are billed at the full rate for a session or per quarter hour.

_____Not attending a scheduled appointment or cancelling an appointment with less than 24 hours' notice will result in a charge for the full session fee of and will be billed to the card on file. This applies to all no shows and late cancellations, regardless of reason. Please note that this fee is not covered by insurance and is subject to change.

I,_____ hereby authorize Monica Urbaniak to charge my credit card on my behalf for all services provided from this day on in accordance with the fees listed above.

In the event of a credit card dispute, this serves as consent for Monica Urbaniak to release this consent/authorization form to the credit card company or bank involved.

Credit Card Number: _____

Credit Card Expiration Date: _____

Security Code: _____

Name as it appears on card:_____

Card owner billing address:

Street: _____

City State, Zip Code: _____

Card owner phone number: _____

_____ _____

Signature Date

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

The effective date of this notice is January 15, 2018.
Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how this office may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect of a minor, elderly or disabled individual
Judicial and Administrative Proceedings
Emergencies
National Security
Protection of your life or someone else's life

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Monica Urbaniak, LMFT-S, 6750 Hillcrest Plaza Drive, Suite 304, Dallas, TX 75230.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

Receipt and Acknowledgment of Notice of Privacy Practices

Client Name: _____ Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Privacy Practices for the practice of Monica Urbaniak, LMFT-S. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Monica Urbaniak, LMFT-S at 214-347-9765.

_____ _____

Client or Parent/Guardian Signature Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.) _____

Communication Acknowledgement and Consent

The following business practices, though not all-inclusive, may constitute a potential risk to your confidentiality, despite the security measures in place to protect your privacy. By signing below, you understand and acknowledge the possible risks and consent for such practices to be utilized.

- Use of electronic calendar
- Use of a cell phone
- Use of a laptop computer
- Use of unencrypted email
- Use of shared office space with other independent practices of mental health professionals with potential access to common storage, file space, and faxes.

_____ _____

Client or Parent/Guardian Signature Date

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