Let It Rain Psychotherapy, PLLC
Sarah Billingsley, LMSW
Supervised by Rayné Ventimiglia, LCSW
Parents Of Child or Teen Intake

Name:__________________________ Date of Birth:_____________ Date:_____________

Ethnicity: Check any/all that apply

______Caucasian ____Black/African American ____Hispanic/Latino ___Native American

______Asian/Pacific Islander ______Other: ______________________________________

Primary Address of Child/Teen:____

Parents phone Numbers (Both): Mom_________________________ Dad_____________________

Email: ____

How does mom/dad want to be contacted: (circle one) Phone Call Email Text

Can I leave a voicemail on cell? (circle one) Yes No

Can I text message appointment reminders: (circle one) Yes No

How did you hear about or find Let It Rain Psychotherapy? (ex: Google, Psychology Today,

Therapist, Friend/Family, etc.) ____

Child/Teen's Primary Physician: ____
Name Address Phone Number

Child/Teen Psychiatrist: ____
Name Address Phone Number

Emergency Contact:

____
Name Address Phone Number

Relationship to Emergency Contact: ____

By giving emergency contact and signing below, I give permission to Sarah Billingsley, LMSW to contact person listed in the event of an emergency.

Signature:____ Date: ___________________

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Main reasons for which you are seeking therapy for your child/teen:
1.____

2. ____

What do you and your child/teen hope to accomplish in Therapy?
1.____

2.____

Child/Teen Medications

Current prescribed medications:____
Over-the-counter medications:____
Past serious medical conditions: ____

Child/Teen Therapy History

Has your child/teen received therapy before? Y or N
If yes, please indicated whether he/she received (circle): In-patient Out-patient Both
What was the reason for previous treatment?__________________________________
When and where treated?____
How long was treatment and previous diagnosis:________________________________

Child/Teen Substance Use

Cigarettes (packs/day):_________________________Age/grade started: _____________________
Alcohol: age started/grade: _____________________ How much alcohol and how often?
Daily amount______________Weekly amount_____________ Monthly amount________________
Drugs (please specify type(s)): ____
Usage: Daily amount: ___________________ How much money spent?_______________________
Weekly amount:_________________ How much money spent?_______________________
Monthly amount:_________________ How much money spent?_______________________

Family History

Please describe any mental health problems had by grandparents, parents, aunt, uncles, siblings, spouse, children such as depression, anxiety, bipolar, schizophrenia or any other mental health problem:

____

____

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Parents Of Child or Teen Intake

Informed Consent to Treatment

Welcome. The purpose of this informed consent to provide psychotherapy for your teen is to make you aware of important aspects of the therapeutic process and have everyone involved understand and be in agreement from the outset. Parents of minors are required to read and sign this consent in order for your teen to become a client at Let It Rain Psychotherapy. Parents who are separated or divorced must provide me with any legal documents affecting their child(ren) and both parents must be present to sign this agreement at the first session or *alternate arrangements must be made with me* (and I am happy to offer accommodations, please call me) so that both parents consent in writing to your teen's therapy. If one of the parents is an absentee parent, I will provide documentation that you are required to sign related to the absenteeism of that parent before therapy with your teen can begin.

What to expect:

Initially, I will gather information from parent(s) about what you believe is troubling your teen, signs and symptoms of mood problems and other disorders, and what you hope your teen with accomplish in therapy. I will then gather information from your teen. Over the first two to three sessions, I will assess and make a treatment plan that includes the therapeutic modality and collaborated goals and objectives. Parent(s) will be informed of the treatment plan and given the opportunity to voice issues or concerns.

Teens often demonstrate resistance, fear, or grief related to receiving therapy although some look forward to it. These reactions are normal. In session, your teen is given the opportunity to do most of the talking. I listen carefully and ask questions to help guide your teen into exploration and discovery of underlying issues and possible solutions to what troubles them. I also help them identify discrepancies between their desires and the behavior getting in the way of the life they really want. Helping your teen increase positive feelings and behaviors is a process that is most successful when therapist and teen collaborate on problem identification, goals, objectives, and solutions.

During your teen's time in therapy she/he may experience feelings of sadness, anger, and anxiety. This is a normal part of the therapeutic process. Your teen has the right to talk to you and me about their positive and negative feelings related to treatment, and I commit to doing everything I can to make their therapy a success. I use cognitive behavioral therapy in combination with other modalities of therapy I believe are most beneficial for the issues your teen is facing. If at any point you feel my therapeutic intervention is not working, please talk to me before stopping therapy. If after talking to me about your thoughts and feelings, you still wish to end your teen's therapy, I can provide referrals to other therapists at your request.

Confidentiality

What your teen discusses with me in session is private and confidential. I will not tell you or anyone what your teen discusses in session, nor will I release your teen's record, without your teen's written consent or court subpoena. I will however, give you any diagnoses and education related to the diagnoses, updates on the general focus of work in session, progress, and my plan for moving the therapeutic process forward. Working with teens at times poses ethical dilemmas that require the consultation of other licensed professionals. Should I use consultation, the identity of your teen will be concealed, and the only dilemma will be discussed so that a decision about the intervention direction is made with the combined wisdom and experience of knowledgeable, skilled, professional therapists.

In order to facilitate a trusting and honest relationship with your teen, I will not violate their right to confidentiality. Honoring your teens right to confidentiality helps her/him feel safe to talk about and receive guidance related to problems and pressure common to most every teen. Your teen may confide information about their experiences and activities of which you may not approve. For example, getting a

tattoo or experimenting with alcohol at a party. These kinds of issues are worked through during therapy sessions and only if and when, in my professional judgement, these activities pose an imminent risk of harm or injuring will I help **the teen inform you**. This is the best way for your child to learn consequences, problem solve, and take responsibility for her/his actions. An example of a situation I would help your teen talk with you about would be if your teen reports she/he consumed alcohol at a party and then drove home intoxicated or got in the car with someone who was intoxicated, or if I believe your teen is addicted to alcohol or drugs. This kind of information will not be withheld from you.

Records
Your teen's record is confidential and will not be shared with anyone. I do not allow parents to view the teen's record if I feel the teen will be harmed emotionally by my doing so. If you have concerns about what your teen is discussing in therapy sessions, please talk to me.

You will find that I keep you quite informed on what your teen is working on and do so without violating your teens confidence.

There are exceptions to your teens right to confidentiality and they are:

Exceptions to Confidentiality
1. If your teen leads me to believe that she/he is planning to harm her/himself or commit suicide and I believe she/he has the means and serious intent to do so, I am obligated to inform teen's parent(s) or guardian(s) of this
2. If your teen leads me to believe she/he is seriously planning to harm or kill another person I am obligated by Texas law and the guidelines of my profession to report this to parent(s) or guardian(s) and the local authorities.
3. If your teen tells me that she/he or a child, elderly person, or person with disabilities was or is being physically or sexually abused, I am obligated by Texas law to report this to the Department of Family and Protective Services (CPS and/or APS).
4. If your teen's records are subpoenaed by the court or a judge, I am obligated by law to comply. I will inform you and your teen of the subpoena and will do all I can within the law to protect your teen's confidentiality.
5. If you or your teen disclose to me that your teen has been "sexting," which has included "pornographic" pictures of your teen or another teen in their messages to others, I am obligated by Texas law to report this to the local police department.
6. It is also pertinent for you to know that I am a Licensed Master Social Worker under clinical supervision by Rayné Ventimiglia, LCSW as I work towards my clinical licensure. This means I am required to review all of my client cases with her to ensure you are receiving ethical treatment within my areas of competency. There will be times when Rayné Johnson, LCSW must review your teen's records to ensure proper documentation and that I meet the standards of our profession as it relates to providing clinical care. *Feel free to discuss any questions or concerns you may have regarding this information with me at any time.*

Cost of services
Forms of payment accepted are cash, debit, and credit. A debit/credit card must remain on electronic file for your teen to be a client here. My fees for the *initial* one hour assessment is $75. In the first session your teen will undergo a clinical assessment which will help us both understand any clinical presentation (diagnosis) she or he has and will direct our problem identification, goals and objectives, intervention, and then, later, the conclusion of our journey together. *After* the initial visit, the fee is **$75 per 50 minute**

session. For **family counseling, my fee is $100 with or without your teen.** You can expect to have at least one family therapy session during the course of treatment. Insurance is not accepted at this time.

Please see Electronic Payment Communications Disclosure form for additional information.

Phone calls
If I am asked to call you between sessions to discuss issues related to your therapy or your child/teen's therapy, you will be charged a fee for that call. Calls initiated by you that require **psychotherapeutic consultation** will be prorated per 15-minute increments at the above costs: $15 per 15 minutes to be paid at the end of the call.

Cancellations
I respectfully request 24 hours advanced notice of your need to cancel a scheduled appointment. **Notice of cancelation less than 24 hours will result in your being charged that day for the full amount of the missed session. There is a $50 no show fee/late cancellation fee for the initial session.** There are some exceptions: if HEB school district cancels school for snowy/icy road conditions; if your child/teen has a medical emergency requiring hospitalization; if there is a death in the immediate family; if I am able to schedule another client in your session time slot. Under these conditions you will not be charged. *Illness is not these exceptions.*

Emergency Contact
I understand that emotional crises sometimes happen after hours. At this time, I am not able to be on-call 24 hours/ If your teen has an emergency during the time I am not keeping office hours, after normal business hours, or if I am with other clients, you must call 911 or go to your nearest emergency room. Currently, when you call me and leave a voicemail. I will respond within 24 hours.

Court Testimony
I do not arrange to offer testimony in court. If you have me subpoenaed by a lawyer or judge and it cannot be quashed, you will be charged $250 per hour with a 4-hour minimum plus a $50 per day per diem. I also charge $25 for copies of any subpoenaed records and $.50 per mile for travel. Please know that I do not make recommendations to the court as to where your teen should live or speak on the character or abilities, or lack there-of, of the other parent. Minimum payment for this service is expected at least one week PRIOR to the scheduled court date and will be charged to the credit/debit card on file. There are no credits or refunds.

Informed Consent to Treatment Continued

In conclusion…

Thank you for the opportunity to work with your teen. Signing below indicates that you have reviewed the policies described above, understand, and agree. If you have any questions as we progress with therapy, you can ask me at any time.

Parent(s)/Guardian(s):
Initial boxes and sign below indicated your agreement to respect your adolescent's privacy:

/______/ I agree to allow my teen to receive psychotherapy from Sarah Billingsley, LMSW of Let It Rain Psychotherapy, PLLC.

/______/ I will refrain from requesting detailed information about individual therapy sessions with my teen. I understand that I will be provided with regular updates about general progress, and/or may be asked to participate in therapy sessions as appropriate.

/______/ Although I know it is my right as a parent to request and receive my teen's record, I understand that Let It Rain Psychotherapy's policy is to disallow anyone to view my teens records. I understand that keeping my teen's record confidential helps her/him become more trusting of parents and therapist, and more willing to work hard in therapy sessions.

/______/ I understand that I will be informed about situations that could endanger my teen. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgements and may sometimes be made in confidential consultation with another licensed therapist.

By my signature below, I attest that I have read, understand and agree with this informed consent and give my full consent for my teen to receive therapy at Let It Rain Psychotherapy, PLLC with Sarah Billingsley, LMSW.

Parent Signature____ Date:____________________

Parent Signature____ Date:____________________

Minor's signature ____ Date:____________________

Therapist Signature____ Date:____________________

Let It Rain Psychotherapy, PLLC
Sarah Billingsley, LMSW
Supervised by Rayné Ventimiglia, LCSW
Parents Of Child or Teen Intake

Teletherapy/Telemental Health Consent

I, ____________________________________, hereby consent to participate in telemental health with, ____ as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at817-874-8169 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Let It Rain Psychotherapy, PLLC
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Parents Of Child or Teen Intake
Teletherapy/Telemental Health Consent Continued

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. Let It Rain Psychotherapy, PLLC-Sarah Billingsley Tele-therapy Informed Consent.

In case of an emergency, my location is: ____

____

and my emergency contact person's name, address, phone: ____________________________________

____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client____Date________________

Signature of Parent if client is a minor_____________________________________ Date ________________

Signature of Parent if client is a minor_____________________________________ Date________________

Signature of therapist____ Date: _______________

Let It Rain Psychotherapy, PLLC
Sarah Billingsley, LMSW
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Parents Of Child or Teen Intake

NOTICE OF PRIVACY PRACTICES

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

I am required by law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I will follow the privacy practices that are described in this Notice. If I amend this Notice, I will provide you with the amended Notice for your information and signature.

For more information about my privacy practices, or for additional copies of this Notice, please let me know your questions as soon as they arise.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Without My Written Authorization. I may use and disclose your PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures of your mental health information that are legally permissible.

Treatment: I may use and disclose your PHI to other clinicians involved in your care in order to better provide integrated treatment to you. For example, I may discuss your diagnosis and treatment plan with your psychiatrist or nurse practitioner. In addition, I may disclose your PHI to other health care providers in order to provide you with appropriate care and continued treatment.

Payment: I may use or disclose your PHI for the purposes of determining coverage, billing, claims management, and reimbursement. For example, a bill sent to your health insurer may include some information about our work together so that the insurer will pay for the treatment. I may also inform your health plan about a treatment you are going to receive in order to determine whether the plan will cover the treatment.

Health Care Operations: I may use and disclose your PHI in connection with health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For, example, I may disclose disguised information about our work for training purposes.

Required or Permitted by Law: I may use or disclose your PHI when I am required or permitted to do so by law. For example, I may disclose your PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. In addition, I may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access your PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; disclosures for workers' compensation claims, and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as authorized by law.

Permissible Uses and Disclosures That May Be Made Without My Authorization, But For Which You Have An Opportunity to Object.

Fundraising: I may use your PHI to contact you in an effort to offer you new services. I may also disclose PHI to any foundation with which I am connected so that the foundation may contact you in an effort to raise money for its operations. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications.

Family and Other Persons Involved in Your Care. I may use or disclose your PHI to notify, or assist in the notification of (including identifying or locating) your personal representative, or another person responsible for your care, location, general condition, or death. If you are present, then I will provide you with an opportunity to object prior to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose your PHI consistent with your prior expressed preference, and in your best interest as determined by my professional judgment. I will also use my professional judgment and my experience to make reasonable inferences of your best interest in allowing another person access to your PHI regarding your treatment with me.

Disaster Relief Efforts. I may use or disclose your PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

NOTICE OF PRIVACY PRACTICES

Uses and Disclosures Requiring Your Written Authorization.

Psychotherapy Notes. I will not disclose the records of our work that I keep separate from the medical record for my personal use, known as psychotherapy notes, except as permitted by law.

Marketing Communications; Sale of PHI. I must obtain your written authorization prior to using or disclosing your PHI for marketing or the sale of your PHI, consistent with the related definitions and exceptions set forth in HIPAA.

Other Uses and Disclosures. Uses and disclosures other than those described in this Notice will only be made with your written authorization. For example, you will need to sign an authorization form before I can send your PHI to your life insurance company or to your attorney. You may revoke any such authorization at any time by providing me with written notification of such revocation.

MY INDIVIDUAL RIGHTS

Right to Inspect and Copy. You may request access to your medical records and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested.

Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Request Restrictions. You have the right to request a restriction on your PHI that I use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to Rayne Johnson, LCSW. I am not required to agree to any such restriction you may request, except if your request is to restrict disclosing your PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf.

Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of disclosures of your PHI made by me in the last six years, subject to certain restrictions and limitations.

Right to Request Amendment: You have the right to request that I amend your PHI. Your request must be in writing, and should explain why the information should be amended. I may deny your request under certain circumstances.

Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to Rayné Johnson, LCSW at any time.

Right to Receive Notification of a Breach. I am required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.

Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, please contact me at 817-874-8169. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint.

EFFECTIVE DATE AND CHANGES TO THIS NOTICE

Effective Date. This Notice is effective on September 2013.

Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office and on my website at www.let-it-rain.org. You may also obtain any revised notice by asking me directly.

This is your copy. Please sign the following page.

Let It Rain Psychotherapy, PLLC
Sarah Billingsley, LMSW
Supervised by Rayné Ventimiglia, LCSW
Parents Of Child or Teen Intake

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of Sarah Billingsley, LMSW's Notice of Privacy Practices.

Printed name of client ____

Signature of client____Date____________________

Signature of LMSW ____Date____________________

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ____

Relationship to Client: ____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign_____
- Communications barriers prohibited obtaining the acknowledgement _____
- An emergency situation prevented us from obtaining acknowledgement _____
- Other(Please Specify)____

This form will be retained in your medical record

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Consent to Communicate Electronically

Communication between sessions is sometimes necessary. The most secure way to communicate so that your confidentiality is protected is by way of phone calls. Text messaging is the next most secure way of communication because my cell phone is password protected. The least secure way of communicating with me is through email. My email is a regular email account through Google. The risk of destroyed privacy is high when using email. Email sent between you and I could be hacked, intercepted, and dispersed to others.

By signing below, you indicate that you have read, and understand, and agree with the above notice of risk. By initialing by your preference(s), you indicate the method of contact for which you give permission.

My therapist has:

____________ Permission to call my cell.

____________ Permission to leave voicemail.

____________ Permission to respond to email from me.

____________ Permission to contact me via text.

____________ Permission to contact me via email.

____________ Do not contact me by any of the above means ***except by phone call.***

Parent/Guardian Signature:______________________________________ Date:____________

Child/Teens Name:____

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ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE

If you wish, you may pay fees electronically – through funds transfer or using a payment card -- using any of the following services:

• *Cayan or TSYS*

Please Be Aware of the Following:
We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible.

After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. We are unable to control this in many cases, and we may not be able to control which email address or phone number your receipt is sent to.

So before using one of the above services to pay for your session(s), please think about these questions:
• At which email address or phone numbers have I received these kinds of receipts before?
• Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
• Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?
• Is it better for me to pay cash to avoid these risks all together?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to *Let It Rain Psychotherapy PLLC*. Please consider who might have access to your statements before making payments by credit or debit card.

I have read, understand, and agree with the above risks of paying electronically by using Cayan/TSYS and I know I have the option of paying by cash.

Parent/Guardian Signature:________________________________Date: _________

Child's/Teen's Name: ____