Client Information Form – Dr Audrey Kteily

Legal Name: _____

Preferred Name: _____

Pronouns: _____

Date of Birth: _____

Address 1: _____

Address 2: _____

City/State: _____ Zip: _____

Mobile Phone: _____ Voice Ok? _____ Text Ok? _____

Home Phone: _____ Voice Ok? _____ Text Ok? _____

Work Phone: _____ Voice Ok? _____ Text Ok? _____

Sex (assigned at birth) _____ Male? _____ Female? _____

Gender Identity: _____

Sexual Orientation: _____

Race/Ethnicity: _____

Languages: _____

Marital Status: _____

Employment: _____

Religious Affiliation: _____

My signature below indicates that I have completed this form and attest to its accuracy.

Printed Name: _____

Date: _____

Signature: _____

Client History Form – Dr Audrey Kteily

Name: _____Date of Birth: _____

Why are you seeking help now?

What is happening or is different? What stressors do you have? What do you hope will be different by seeking help?

Please give more details about the issue you named above:

When did it start? How often does it happen? How does it affect your life? How have you dealt with it so far?

Have you ever experienced similar or other mental health symptoms before?

If so, what was your experience like? When did it happen? Did you get help?

Has anyone in your family ever experienced mental health or substance use issues?

If so, who was it? Did they seek help or get a diagnosis? What was it like for them? What was it like for you?

Do you have any current or prior medical issues?

If so, what was/is it? Have you seen a doctor or other healthcare professional for it?

What recommendations or treatment did you have? Is there any family history of disease?

Are you currently prescribed any medications?

If so, please list the name, dosage, how often you take it, and the prescriber for each medication.

Do you now, or have you ever, used alcohol, tobacco, recreational drugs, or prescription medication other than as prescribed?

If so, which? When did you start, how often did/do you use, and how long did this occur? Please list each substance separately.

Who is in your family? What is your relationship with them like?

Please list all individuals you consider to be a part of your family. For those who are not part of your family of origin (such as significant others), please include the duration of your relationship.

What social activities and relationships do you engage in?

What important social relationships do you have? Do you belong to any social clubs or organizations? How do you like to spend your leisure time?

What spiritual practices and cultural influences are important to you?

Do you belong to a religious, faith, or spiritual community? What other cultural groups do you identify with? How do you celebrate culture and spirituality in your life?

What was life like as you were growing up, both at home and in school?

Did you meet developmental milestones on time or experience any delays?

What were your friends like when you were younger? What was school like for you?

Client History Form – Dr Audrey Kteily

What significant educational and work/volunteer experiences have you had?

What is the highest level of education you have completed?

Are you currently employed? If so, where and for how long?

What other work and educational experiences have you had (such as a stay-at-home parent or semester abroad)?

Are you satisfied with your current employment and education?
Do you have any current or prior legal issues?

Were you ever arrested or charged with a crime or misdemeanor?

Do you have any involvement with the civil courts, such as a lawsuit or family law matter? If so, please describe them.

What strengths and abilities are you bringing to sessions? What needs or preferences do you have that will help us be successful?

What coping skills have been working for you so far? What is important to know that will help make our time more effective for you?

What else is important to know about you?

My signature below indicates that I have completed this form and attest to its accuracy.

Printed Name: _____

Date: _____

Signature: _____

Client Emergency Contact Form – Dr Audrey Kteily

Contact Name: _____

Relationship to client: _____

Date of Birth: _____

Street Address: _____

City and Zip: _____

Mobile Phone: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

My signature below indicates that I have completed this form and attest to its accuracy.

Printed Name: _____

Date: _____

Signature: _____

Informed Consent and Office Policies – Dr Audrey Kteily

Welcome to Dr Audrey Kteily's practice!
Choosing a therapist is a very personal decision and should not be made lightly. Therapy can be intimidating, difficult, and even scary – but it doesn't have to be. Dr Audrey looks forward to making therapy a productive and safe space and is honored to join you on your journey.

What is the therapy process?
At the first session, Dr Audrey gets to know you and what prompted you to come in. She assesses the situation and offers initial impressions at that time. She will make recommendations for further treatment, how often, etc – but she involves the client every step of the way. Session times are scheduled on the hour and typically take 45-50 minutes.

Psychotherapy has both risks and benefits. Psychotherapy often requires discussing unpleasant times in your life and the difficult feelings that come with that. Most of the time, however, opening difficult areas in a safe supported environment actually reduces feelings such as distress, sadness or anxiety. Everyone's process and progress are different. Dr Audrey endeavors to create a warm safe space to allow safety, warmth, and growth.

What qualifications do you have?
Dr Audrey Kteily holds a PhD in Family Studies/Family Therapy from Texas Woman's University, as well as a MA in Counseling from Dallas Baptist University and a BA in Psychology from Texas Woman's University. Dr Audrey is a Licensed Professional Counselor – Supervisor in the state of Texas and has over 20 years' experience in multiple, varied areas.

Is what we discuss confidential?
Generally, the communications between a client and a therapist are protected by law and a therapist can only release information about your sessions with your written consent. However, there are a few exceptions to this rule that you need to be aware of.

1. **Danger to Self/Others and Reporting Abuse**: If a therapist believes that a client presents a danger to him/herself or to someone else, they are required to take protective actions. If a child, elderly person, or disabled person is suspected of being abused, a report must be filed with the appropriate legal agency.
2. **Court Proceedings and Requests**: If you are involved in court proceedings and a request is made for information about your treatment, you will be notified immediately. Dr Audrey will speak with you before releasing the information, however, please understand Dr Audrey is bound by law to respond accordingly.
3. **Legal Involvement**: If at any time a client involves Dr Audrey Kteily in any legal proceedings including (ex: having a subpoena issued by an attorney or court, requesting a deposition, or threatens Dr Audrey or her practice in any way, Dr Audrey will involve her attorneys in order to follow the best legal and ethical practices for her practice and herself.
4. **Parents and Minor Children**: If the client is a minor and is engaging in reckless behavior or persistent substance abuse, parents will be notified. Dr Audrey will work with the minor client to tell their parents about their situation. If the minor client cannot do so, Dr Audrey will inform

the parents with the minor client present. Dr Audrey takes every effort to keep the minor client's confidence while making sure parents are fully informed.

5. **Parent Consults, Family Sessions, Group Sessions:** Anytime we are working with more than one client in a therapeutic setting, anything you say may potentially be accessed by others in the room. Every person in the room will be required to sign an ROI for all other people in the room. This safeguards the clients, and the practice should legal involvement occur at a later time.
6. **Electronic Communication**: HIPAA states that communication with clients must be done through an encrypted system. All systems Dr Audrey uses are HIPAA approved, however, there is no guarantee that your Protected Health Information (PHI) is completely safe. Should you choose to communicate to us electronically please understand that information exchanged this way is NOT protected.

Can I access my own records?

1. You are entitled to a copy of your treatment records. The request must be made in writing, and the state allows up to 15 days to respond. If requesting your complete record, Dr Audrey highly recommends reading through it with her so she can assist with anything that is upsetting or confusing. Most often a summary of treatment suffices and causes much less confusion.

Scheduling Policies

1. **Communication**: Dr Audrey responds to all communications for her practice. All emails sent from Dr Audrey are HIPAA compliant and encrypted. Most of the day, Dr Audrey is in session and cannot answer live calls. Dr Audrey returns voicemails as quickly as possible but is often not able to do so same day. Therefore, if you require immediate assistance, please call 911 or head to the nearest ER.
2. **Scheduling**: Clients must be 18 years of age to seek services and to make their own appointments. Clients under the age of 18 must have a parent or legal guardian make their appointment for them. Parents and older teens are highly encouraged to come in before their child turns 18 to discuss the changes that will occur regarding HIPAA, access to care, etc.
3. **Cancellations/Late/Missed sessions**: If you need to cancel or reschedule your appointment, Dr Audrey asks that you kindly give 24-48 hours' notice to avoid fees and to open a slot for someone else that could use it. Sessions are 45-50 minutes long. Patients running 15 or more minutes late may be asked to reschedule. A missed appointment fee will be assessed if the client does not call or appear for their session at all. Two or more consecutively missed appointments without communication to the office will result in loss of that time slot. If a minor client or a person over the age of 18 is being covered by their parent/guardian's insurance policy incurs fees, the guardian/guarantor will be held legally responsible for any fees incurred, including missed appointment and cancellation fees.

Billing Policies

1. **General**: All payments and copays are due at the time services are rendered. Cash and credit cards are the only forms of payment accepted. An active credit card must always remain on file. If using HSA or FSA cards, a backup credit card is required. Failure to provide payment for sessions may result in suspension of therapy, additional late fees and charges, or the practice using legal means to collect unpaid fees.
2. **Insurance:** Dr Audrey takes United/Optum only. If you are not using United/Optum you will pay a cash fee. Dr Audrey will send client statements monthly to help clients seeking reimbursement

or accessing out of network benefits. Clients are responsible for all charges not covered by insurance, for understanding their own benefits and coverage, and for notifying the practice immediately if benefits or policies change. By consenting for Dr Audrey's practice process your claims, you are agreeing that the practice will release all necessary information for claims to be processed; that the practice will be reimbursed for services based on those claims and that you are authorizing payment directly to Dr Audrey Kteily's practice.

3. **Fees:**
    a) **Litigation Fees**: Should litigation occur that mandates Dr Audrey's full participation, Dr Audrey requires a retainer of $4000/day ($500/hour). If a client is involved in a lawsuit that creates a situation where we are court ordered to be involved, we will bill the initiating party for services rendered. If the charges are not paid at the time of services rendered, the fees will become the client's responsibility. Litigation fees must be paid in a timely manner. Litigation fees that remain unpaid for more than 14 calendar days may be sent to a collection agency in order to secure payment.
    b) **Records Request Fees**: There is a $75 fee charged for completion of filling out forms and/or copying records of any kind. We require you to provide us with authorization to release your information to anyone but yourself. These include but are not limited to the following: treatment verification letters, compilation and/or copying of treatment files, human resources documents (these will only be completed if we are legally able), and school district requests of any kind. You should allow up to 2 weeks for processing of these requests.
    c) **Missed appointment fee**: Full cash rate
    d) **Phone Consult Fee:** $50 per 15 min.

Telehealth Policies

1. Dr Audrey provides in person and virtual therapy appointments where applicable. Virtual counseling is not appropriate for everyone, and it is not intended to be a replacement for in-person counseling services. Wherever possible, clients are encouraged to attend traditional, in-person counseling sessions.
2. Virtual services are not recommended for individuals who have experienced major psychotic episodes, behavioral health hospitalizations, or who have a history of addiction/substance abuse. Virtual services are not recommended for individuals who have a diagnosis that requires a higher level of care than outpatient care. Virtual services are not appropriate for individuals who are experiencing suicidal, homicidal, or violent ideations and/or behaviors.
3. Dr Audrey does not consent to having any of her sessions recorded, nor will she record any session regardless of how it is held. The laws that protect the confidentiality of personal information also apply to telehealth.
4. Teletherapy refers to psychotherapy services which are rendered remotely using telecommunications technologies such as video conferencing or telephone. This requires some technical competence on the client's part and comes with a few risks:
    a) **Risks to confidentiality**: Dr Audrey provides teletherapy from her office, which is a HIPAA compliant, confidential space. It is very important that clients also secure their privacy for teletherapy to be effective. Clients should find a space that is private and secure, use headphones if needed, and using a protected device and/or connection.

b) **Issues related to technology:** Dr Audrey mainly uses the portal via her Electronic Medical Record as it remains very stable. That said, she has HIPAA compliant backups to use as well (Google Meet and Doxy – both BAA signed). It is the clients responsibility that they understand technology enough to secure end of the session, and have a strong internet connection. If technology interruptions persist, Dr Audrey may ask to reschedule in order for the session to run smoothly.
c) **Crisis management and intervention**: Telehealth services are not appropriate for clients that are in crisis. If a higher level of care is deemed necessary, Dr Audrey will work with her clients or her clients parents to secure the clients safety.
d) **Emergencies and contact plan:** An emergency is defined as a situation where clear and imminent risk of harm to self or others is present. Assessing and evaluating threats and other emergencies is made more difficult when conducting teletherapy. Dr Audrey will follow all applicable laws and use all possible resources to secure her client's safety.

Boundaries of the Therapist-Client Relationship

1. **Conflict of Interest**: In being a part of your treatment, it often feels like your therapist becomes part of your family system. However, boundaries must be maintained in order to protect the therapeutic relationship. Dual roles must not be formed intentionally or unintentionally. If this occurs, Dr Audrey will discuss it with you and create a plan that is therapeutically correct.
2. **Giving of Gifts**: The Texas State Board prohibits LPC's from accepting cash, services, or gifts valued at or over $50.00.
3. **Discontinuation**: You are free to discontinue counseling at any time, but for your benefit, we encourage you to collaborate with your therapist regarding the decision to discontinue therapy. If at any time, your therapist determines that they are unable to help you , due to a specific issue or because their training and skills are not suitable to provide you with the best quality of care, they will discuss this with you and refer you to another therapist or practice who can meet your needs.
4. **Termination**: Non-compliance with counseling recommendations, not attending sessions, and/ or cancellations that are outside of the policy may necessitate early termination of services.

Complaints and Concerns

Should you have any complaints or concerns about your therapy, please speak with Dr Audrey immediately. Dr Audrey's chief concern will always be that you receive the best possible care. If your care requires something Dr Audrey does not provide, she will do her best to help you find a provider that can help. Examples of services Dr Audrey does not provide (psych testing, court or custody related evaluations, divorce mediation, expert testimony).

With my signature, I acknowledge:

That I have read and understand Dr Audrey Kteily's Informed Consent and Office Policies. That Dr Audrey Kteily reserves the right to update and/or change its policies at any time and those updated policies will immediately supersede any previous versions.

Printed Name: _____

Date:_____

Signature: _____

Client Insurance Form – Dr Audrey Kteily

Name: _____Date of Birth: _____

Insurance Company:_____

Member/Beneficiary ID:_____
Priority:_____

Policy Group:_____
Plan Name:_____

Policy Holder:_____

Client Relationship:_____

I understand and agree to the following:

- I authorize the release of information from my medical record to the insurance company or other third-party payer named above. This information shall include all information necessary to submit and process claims, such as my name, date of birth, address, medical diagnosis, and services provided to me.
- If the practice has already shared information with the insurance company or other third-party payer at the time I revoke this authorization, it is too late to prevent that information from being shared.
- This authorization is necessary for the practice to determine eligibility for treatments or benefits or to pay for treatments I receive, but the practice cannot condition treatment on the provision of this authorization.
- This authorization shall be effective for one year or until I revoke it.
- If benefits change I acknowledge it is my responsibility to inform the practice as soon as possible.
- In consideration of the services provided to me, I assign all benefits to the practice, if accepted, and authorize this insurance company to make payments directly to the practice and its affiliates on my behalf.

My signature below indicates that I understand and agree to all listed above.

Printed Name: _____

Date: _____

Signature: _____

NOTIFICATION OF PRACTICES AND POLICIES REGARDING HIPAA
Dr Audrey Kteily

Your health record contains personal information about you and your health. This information about you, which 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 Notification of Policies and Practices describes how we may use and disclose your PHI in accordance with applicable laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

The term "use" applies to activities within this practice such as sharing, employing, applying, utilizing, examining, and analyzing PHI that identifies you. The term "disclosure" applies to activities outside this practice such as releasing, transferring, or providing access to PHI about you to other parties. We may use or disclose your PHI for the following reasons:

1. **Treatment.** This occurs when we provide, coordinate or manage your health care and related services. An example of treatment is when we consult with another health care provider, such as your family physician.

2. **Payment.** This occurs when we obtain reimbursement for your healthcare. An example of payment is when we disclose your PHI to your health care insurer to obtain reimbursement for services or to determine eligibility or coverage.

3. **Health Care Operations.** These are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

4. **As Required by Law.** Under HIPAA, we must disclose 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 HIPAA Privacy Rule.

II. Uses and Disclosures with Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

1. **Child Abuse or Neglect**: We may disclose your PHI to a state or local agency that is authorized to receive reports of child abuse or neglect, as required or authorized by Texas or federal law.

2. **Elder or Disabled Abuse or Neglect**: We may disclose your PHI to a state agency that is authorized to receive reports concerning the abuse of an elderly person or disabled persons, as required by Texas or federal law.

3. **Abuse by a Mental Health Professional**: We may disclose your PHI to the appropriate licensing board in making a report of sexual abuse by a mental health professional as required by Texas or federal law.

4. **Health Oversight**: If a complaint is filed with the Texas State Board of Examiners of Professional Counselors, they have the authority to subpoena confidential mental health information from Coppell Family Therapy that is relevant to that complaint.

5. **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged. We will not release such 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 medically evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

6. **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

7. **Deceased Patients:** We may disclose PHI regarding deceased patients as mandated by state or federal law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior written consent or authorization. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next of kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

8. **Law Enforcement:** We may disclose PHI to a law enforcement official as required by law in compliance with a court order, administrative order, or similar document for the purpose of identifying a suspect, material witness, or missing person in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency or in connection with a crime on the premises.

9. **Public Safety:** We may disclose your PHI if 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 the person or persons reasonably able to prevent or lessen the threat (for example, the police), as permitted by Texas or federal law.

IV. Patient's Rights and Practitioner's Duties

1. **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

2. **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 alternative locations. (For example, you may not want a family member to know that you are seeking therapy.) Upon receipt of your written request, we will update our records to send your correspondence to the alternative address or by an alternative means.

3. **Right to Inspect and Copy Notes:** You have the right to inspect or obtain a copy of PHI in our mental health and billing records. These may be used to make decisions about you for as long as the PHI is maintained in these records. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. Upon receipt of a written request, we will discuss with you, at a mutually acceptable time and place, the details of the request and denial process and your right to appeal.

4. **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in these records. We may deny your request. Upon receipt of a written request, we will discuss with you the details of the amendment process.

5. **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). Upon receipt of a written request, we will discuss with you the details of the accounting process.

6. **Breach Notification:** If there is a breach of unsecured PHI concerning you, we are required to notify you of this breach, including the circumstances of the breach and what you can do to protect yourself.

7. **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Practitioner's Duties: We are required by law to maintain the privacy of PHI and to provide you with an updates regarding our compliance with PHI protection. Updates to this notice will be displayed on-site, our website, and by request via printed form, mail or secure email.

V. Questions and Complaints
If you have questions about this notice or believe your privacy rights have been violated, you have the right to file a complaint in writing with the owner of this business: Audrey Kteily PhD LPC-S at 684 S Denton Tap Suite 110 Coppell TX 75019 or with the Texas State Board of Examiners of Professional Counselors / Complaints Management and Investigative Section at PO Box 131369 Austin TX 78714-1369.

My signature below indicates that I have read about and understand my rights /my minor child's rights under HIPAA regarding privacy and confidentiality.

Printed Name: _____

Signature: _____

Date: _____

Client Payment Agreement – Dr Audrey Kteily

I do not have or do not want to use any insurance benefits. I will be responsible for all charges related to the services rendered.

I agree to pay the cash fee of $225/session and agree that I will be charged this fee each time sessions are held.

I agree to keep a credit card on file with the practice and if using HSA/FSA I agree to keep a backup credit card on file as well.

My signature below indicates that I understand and agree to all listed above.

Printed Name: _____

Date: _____

Signature: _____

Payment Authorization Form – Dr Audrey Kteily

Name on Card: _____

Card Number: _____

Card Exp Month and Year: _____

Security Code: _____

Billing Address: _____

Billing City, State, Zip: _____

I acknowledge that:
The practice may utilize my payment methods on file for any balances (including late cancellation and/or and no-show fees, unpaid insurance claims, etc) without additional authorization.

My signature below indicates that I have completed this form and attest to its accuracy.

Printed Name: _____

Date: _____

Signature: _____