Norma J. Cruson, M.Ed., NCC, LPC-S, RPT-S

UNT CPT Certified Child-Centered Play Therapy Clinician ***EMDRIA Trained EMDR Clinician***

116 Taylor Street Office: (817) 932-3158 crusoncounseling@gmail.com
Keller, Texas 76248 Fax: (817) 760-8387 www.kellerchildtherapist.com

Adolescent As Client Intake Information Form

I am pleased you are bringing your child to work with me. As part of our time together, I'd like you to be aware of the following:

- I am a Master's level Licensed Professional Counselor-Supervisor in the state of Texas, a Nationally Certified Counselor, a Registered Play Therapist-Supervisor, a UNT Center for Play Therapy Certified Child-Centered Play Therapist, and an EMDRIA Trained EMDR clinician.
- I work with children, adolescents, adults, and families on a variety of issues.
- You are in control of this relationship and you may choose to end it at any time.
- If we meet in a public or social situation, your confidentiality will be protected and we will acknowledge knowing each other only if you wish to do so.

Office Policies and Procedures

I strive to provide the most considerate care possible for my clients. It is important to me your visits be pleasant and comfortable.

1. Animal Assisted Therapy Dogs: Roscoe and Max, Scottish Terriers, are often on the premises to assist clients during their sessions. Please let me know ahead of time if you have any concerns regarding their presence in the office.
2. Late Arrivals: If you are scheduled for an appointment and arrive 15 minutes late or later, you may not be seen.
3. Contacting Me: Please wait until scheduled appointments to discuss issues you would like to share rather than phoning or e-mailing between sessions. *If you experience a life-threatening emergency, go to the nearest emergency room or dial 911.*
4. Waiting Room: I kindly request only those receiving services come to an appointment to minimize distraction and noise.
5. Play Room/Sand Tray Room: The play room and the sand tray room are for therapeutic use only and to be entered only when accompanied by the therapist. Please leave sound machines "on" to avoid conversations being heard in the waiting room.
6. Accessibility: Should you desire, you are welcome to arrive and be seated in the waiting room as early as 20 minutes before your session. I may be with another client(s), so please have a seat and I will be with you at your scheduled time.
7. Unattended Minor Children: Please do not leave children unattended in the waiting room or on the property grounds.

Rates and Fees

You are responsible for all fees at the time of service and this office accepts cash, credit cards, or checks. Norma J. Cruson, M.Ed., NCC, LPC-S, RPT-S is an out-of-network provider with some insurance providers, giving clients the necessary paperwork to file their own insurance reimbursements.

_____ (please initial): A minimum of 24-hours notice is required to cancel an appointment without incurring a fee.
_____ (please initial): No-shows and late cancellations will be charged the full session fee.
_____ (please initial): If you miss more than two consecutive scheduled appointments you will be asked to provide a valid credit card to be kept on file that will be used to charge for those and future missed sessions.
_____ (please initial): Late, cancelled, or missed appointments are paid in full at the next appointment.
_____ (please initial): This office does not provide custody evaluations or make recommendations regarding custody agreements or legal marital issues. Neither testimony nor summary of sessions for the purpose of custody or divorce issues will be provided to any legal representative. If, however, a subpoena to testify or provide session information is ordered by a presiding judge, the fee to the party demanding such services will be $180.00 per hour for all activity related to providing such a service including travel, note preparation, copying, etc., plus a prepaid $3500.00 retainer fee.

Service	Length of Service	Fee for Service
Parent Consult (w/o child)	50 minutes	$130 cash/check or $135 credit card
Individual Child Session	50 minutes	$130 cash/check or $135 credit card
Individual Adult Session	50 minutes	$130 cash/check or $135 credit card
EMDR 90 minutes, adult	90 minutes	$160 cash/check or $165 credit card
Group Sessions for Child/Adult	50 minutes	$60 per client
Couples Counseling	50 minutes	$160 cash/check or $165 credit card
Letter writing or court preparation of notes	60 minutes	$60 per hour
Insufficient Funds Returned Check		$25
Missed appointment or cancellation with less than 24-hour notice		$130, paid at next appointment

ADOLESCENT INTAKE FORM (ages 12-17)

Please fill out as completely as possible. Adolescent please fill out pages 2-3, parent/guardian please fill out pages 4-10

Name: ____ Date of Birth: _____/______/____________
Age: _____ Male___ Female___ Phone (Cell): ____________________________Messages okay?___ Text reminder okay?___
School: ____ Grade: ________________
Electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) you use: _______________________________________
Do your parents have access to your electronic communication? (Y/N) ___ Do they have any issues with your use of phone, text, electronic communication? (Y/N) _______

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? ____
____
Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)
____
____

CURRENT REASON FOR SEEKING COUNSELING/COUNSELING HISTORY

Briefly describe the problem for which you are seeking to have counseling? ____
____
What would you like to see happen as a result of counseling? ____
____
Have you previously seen a counselor? _____Yes _____No
If yes, what did you find **most helpful** in therapy? ____
If yes, what did you find **least helpful** in therapy? ____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes, _____No
If yes, how often do you drink? ____Daily, _____Weekly, ____Occasionally, ____Rarely How much do you drink? _______ per time.
Do you currently use Tobacco? ______Yes, _____No If yes, how much do you smoke/chew? _____________________________
Do you currently use any other drugs? ____Yes, ____No If yes, what drugs do you use? ___________________________________
If yes, how often do you use? _____Daily ______Weekly ______Occasionally _____Rarely
Have you received any previous treatment for chemical use? Y/N _____ Was it ___Inpatient or _____Outpatient?
If so, where did you go?____

1. Have you ever used more than 1 chemical at the same time to get high? ____ Yes, ___ No
2. Do you avoid family activities so you can use? ___ Yes, ___ No
3. Do you have a group of friends who also use? ___ Yes, ___ No
4. Do you use to improve your emotions such as when you feel sad or depressed? ___ Yes, ___No

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.____

FAMILY HISTORY

1. Are your parents married or divorced? ____
2. Do you think their relationship is good? (Y/N/Unsure)____
3. If your parents are divorced, whom do you primarily live with? _____________
4. How often do you see each parent? Mom____________% Dad ______________%.
5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. ____

FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing)

___Fighting
___Feeling distant/disconnected
___Loss of fun
___Lack of honesty
___Physical fights
___Disagreeing about relatives
___Disagreeing about friends
___ Financial problems
___ Divorce/separation
___ Abuse/neglect
___Alcohol or Drug Use
___ Inadequate housing/feeling unsafe
___ Birth of a child
___ Job change or job dissatisfaction
___ Death of a family member

PEER RELATIONS

1. How are you socially: ___outgoing ___shy __depends
2. Are you happy with you amount of friends ? (Y/N)_____
3. Are you involved in any organized social activities (e.g. sports, scouts, music)? ____
4. Have you been bullied (Y/N) _____
5. Are your parents happy with your friends? (Y/N) _____

SCHOOL HISTORY

1. Do you like school? (Y/N)______________
2. Do you attend regularly? (Y/N) __________
3. What are your current grades? _____________________
4. Do you feel you are doing the best you can at school? (Y/N)_____

INDIVIDUAL CONCERNS: Please check all that apply.

Symptom	None	Mild	Mod	Severe		Symptom	None	Mild	Mod	Severe
Sadness						Poor Concentration				
Crying						Appetite Changes				
Sleep Disturbances						Social Isolation				
Problems at Home						Paranoid Thoughts				
Hyperactivity						Indecisiveness				
Binging/Purging						Low Energy				
Loneliness						Excessive Worry				
Unresolved Guilt						Low Self Worth				
Irritability						Anger Issues				
Nausea/Indigestion						Spiritual Concerns				
Social Anxiety						Hallucinations				
Self-Mutilation						Racing Thoughts				
Easily Distracted						Restlessness				
Impulsivity						Drug or Alcohol Use				
Nightmares						Hopelessness				
Elevated Mood						Mood Swings				
Disorganized						Anorexia				
Grief						Phobias				
Headaches						Weight Changes (Unplanned)				
Feeling Anxious/Panicky						Panic Attacks				
Trauma Flashbacks						Obsessive Thoughts				
Past Suicide Attempts						Suicidal Thoughts				

ADOLESCENT AS CLIENT INFORMATION

Today's Date: ____/_____/_________ Name of Person Completing this Form:____
Child's First Name: ___________________________________ Middle: _________Last:____
Date of Birth:______/_______/___________Age: ______ Preferred to be called/nickname: _________________________________
Address Street: _______________________________________ City:________________________ State: ______Zip: ___________

PARENT/GUARDIAN INFORMATION
Mother: First Name:_________________________ Last Name: _______________________________ DOB: ___/____/_______
Home Phone: _______________________ Cell: ______________________ Work Phone: ________________________________
Home Address: Street/Apt. #_____________________________________City: ___________________________ Zip:____________
E-mail: ____ Preferred method of contact: ____cell ____ text ____email

Father: First Name:_________________________ Last Name: _______________________________ DOB: ___/____/_______
Home Phone: _______________________ Cell: ______________________ Work Phone: ________________________________
Home Address: Street/Apt. #_____________________________________City: ___________________________ Zip:____________
E-mail: ____ Preferred method of contact: ____cell ____ text ____email

Legal Guardian (if applicable): First Name: ___________________________ Last Name: ________________ DOB:___/___/______
Home Phone: ________________________ Cell: ______________________ Work Phone: ___________________________________
Home Address (Street/Apt. #): ___________________________________City: ___________________________ Zip: _____________
E-mail: ____ Preferred method of contact: _____ cell ____ text ____email

Child is living with (circle one):
A) both natural parents/only living parent B) divorced/separated natural parent (who and since when)___________________________
C) Father remarried (when)______________ D) Mother remarried (when)__________________________
E) Guardian (when) _________________________ F) Adopted---Age at adoption: _____ Adoption date: _________________

If conditions B, E, or F, apply, please provide a photocopy of the legal document stating this information [cover page, page specifying conservator(s) and signature page]. The photocopy should be stapled to this form.

Recent move? Yes [ ] No [ ] Child has own room? Yes [ ] No [ ] Shares room with: _____________________________
Pet? Yes[ ] No[ ] Type:_____________Negative experiences with animals? Yes[ ] No[ ] Explain:_______________________
Chores/responsibilities? Yes [ ] No [ ] List: ____

DEVELOPMENTAL HISTORY

1. Have there been physical or emotional separations between child and care-taking adults from child's birth to present time? ___Yes __No Describe:____________________
2. Was delivery normal? _____Yes _____No ____Unknown
3. Did birth mother experience physical or emotional problems during pregnancy? ____Yes ____No ___Unknown
4. Were medications taken during pregnancy? ___Yes __No
5. Did birth mother consume alcoholic beverages or abuse street drugs during pregnancy? _____Yes ___No __Unknown
6. Did baby experience any problems immediately after birth? ________Yes ________No ______Unknown
7. At what age did child: ___smile *(6 mos)*
___sit alone *(6-10 mos)* ___roll over (*6 mos)*
___hold head up (*3-4 mos)* ___crawl (*6-10 mos)*
___walk *(12 mos)* ___feed self (*2yrs)*
___ talk in single words (*18-24 mos)* ___ ride bike *(6 yrs)*
___ talk in sentences *(30-36 mos)*
___ establish toilet training *(2 ½-4 yrs)*

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try? ____
____
What personal qualities would you say your son or daughter has? ____
____
Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe) ____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) ____ If yes, please explain your concern: _______________________________________

LEGAL ISSUES

Please list any legal issues past or current that are affecting you or your family, son or daughter, at present: __________________

____

CHILD'S MEDICAL and PSYCHIATRIC/PSYCHOLOGICAL TREATMENT HISTORY

Current medications: ________________________________

Allergies/chronic conditions: __________________________

Problems with health, disease, or serious injury:

____

Has the child been hospitalized? _____Yes ______No

Age when hospitalized _____Reason___________________

Date of last doctor visit:______________________________

Does child have a vision problem? _____Yes _____No

If yes, describe_____________________________________

Does child have a hearing problem? _____Yes ____No

If yes, describe_______________________________________

Does child have a speech problem? ____Yes ____No

If yes, describe ______________________________________

Does child have convulsions or spells? ____Yes _____No

If yes, explain_______________________________________

Anything else I should know regarding child's medical condition? ____

Has child received **prior** psychiatric/psychological treatment? _____Yes _____No If "yes", please list:

Provider:_____________________________ Address: ___________________________________ Phone:__________________

Dates of Service: ____________________________ Reason for receiving treatment: ___________________________________

Reason for ending treatment: ____________________ (Please use back of form if you need to list more similar providers)

What did you find most helpful in therapy: ____

What did you find least helpful in therapy: ____

Is the child **currently** under the care of a psychologist/psychiatrist? _______ Yes _______ No

Provider: _____________________________ Address: _________________________________ Phone: ________________

Dates of Service: ___________________________ Reason for receiving treatment: ____________________________________

Any developmental testing? _____Yes _____ No Dates: _______________ Place: _________________________________

Findings: ____

SCHOOL INFORMATION (Grade in School___) Child has been: Tutored: Yes[ ]No[ ] In special classes: Yes [ ] No [ ]

Expelled: Yes [ ] No [ ] Suspended: Yes [ ]No [ ] Repeated a grade: Yes [ ] No [ ] Cut classes: Yes [ ] No [ ]

Bullied by other students: Yes [ ] No [ ] Bullies other students: Yes [ ] No [ ]

The school has said my child: Is hyperactive_____ Is bored_____ Procrastinates_____ Has few friends_____

Gets along with adults ___ Gets along with students ___ Has many friends ___ IQ above avg __ IQ below avg__

My child enjoys which subject(s) or experiences most in school: ____

My child attends (name of school): ____

SIBLINGS/PARENTING QUESTIONS

	Name	Age	Relationship (good, bad, etc.; please also note if step-siblings)
Siblings:	____________	______	______________________
	____________	______	______________________
	____________	______	______________________
	____________	______	______________________
	____________	______	______________________

Who makes parenting decisions most often? ____________________ Do you agree on childrearing methods? Yes [ ] No [ ]

Form of discipline used by father? _______________________ Form of discipline used by mother? _______________________

Child seems to respond best to what type of discipline: ____

ABUSE HISTORY

If the child was abused, please enter the information below. For kind of abuse, please use the letters:

P = physical, such as beatings ***S*** = sexual, such as touching/molesting/fondling/intercourse/exposure to pornography

N= neglect, such as failure to feed, shelter, or protect or abandonment ***E*** = emotional, such as humiliation, etc.

Age at Time of Abuse	Kind of Abuse	By Whom?	Did child tell?	Consequences of telling

SUBSTANCE ABUSE INFORMATION (When appropriate, child/adolescent should answer the following questions).

Substance	Age 1st Began	Highest Use	Date Last Use
Alcohol		__Daily __Few times/wk __Wkends __Sometimes	
Marijuana		__Daily __Few times/wk __Wkends __Sometimes	
Cocaine/Crack/Meth/Speed		__Daily __Few times/wk __Wkends _Sometimes	
Heroin/Opiates		__Daily __Few times/wk __Wkends __Sometimes	
Inhalants		__Daily __Few times/wk __Wkends __Sometimes	
Hallucinogens		__Daily __Few times/wk __Wkends __Sometimes	
Prescription abuse		__Daily __Few times/wk __Wkends __Sometimes	
Tobacco (smoke or chew)		__Daily __Few times/wk __Wkends __Sometimes	
Other		__Daily __Few times/wk __Wkends __Sometimes	

SELF-HARM/HARM TO OTHERS RISK ASSESSMENT

Has the child ever had suicidal thoughts? _______Yes ________ No _______Unknown by person completing form

If "yes", does the child currently have these thoughts? _____Yes ______No _____Unknown by person completing form

Has the child ever had thoughts about harming others? _____ Yes _____No _____Unknown by person completing form

If "yes", does the child currently have these thoughts? _____Yes ______No _____Unknown by person completing form

Has the child ever attempted suicide? _______Yes _______No ________Unknown by person completing this form

CURRENT REASON FOR SEEKING THERAPY FOR YOUR ADOLESCENT:

Briefly describe the problem for which your adolescent is seeking therapy?____

____

What would you like to see happen as a result of counseling? ____

____

What is most concerning right now? ____

CONSENT FOR TREATMENT OF A MINOR CHILD

Your child has the right to private, confidential communication with the therapist providing his/her care. Some of the issues they discuss will not be disclosed to you unless given permission by your child to do so. We recognize it is important for you to know what your child is going through in order to do your job as a parent, thus we always encourage your child to be honest with you. We will encourage, prepare and support your child so they feel safe enough to share those issues with you.

The following statements provide your legal consent to and financial responsibility for counseling services to a minor child.

STATEMENT OF RESPONSIBILITY AND GRANT OF PERMISSION FOR THERAPY
I am the: Natural Parent of: [ ] Legal Guardian of: [ ] Managing Conservator of: [ ]

____
Name of minor child

I am legally responsible for the child named above and grant permission to Norma J. Cruson, M.Ed., NCC, LPC, Registered Play Therapist to conduct therapy with this child. I give you, Norma J. Cruson, M.Ed., NCC, LPC-S, RPT-S full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s), and/or guardian(s) of said child. We/I, have the legal power to consent to medical, psychological and mental health assessment and treatment of said minor child. It is clearly understood you are hereby fully released from any claims and demands which might arise, or be incident to the evaluation and/or treatment provided your duties are performed with standard care and responsibility to the best of your professional ability. Furthermore, I accept responsibility for timely payment of all fees due Norma J. Cruson, M.Ed., NCC, LPC-S, RPT-S for services provided to this child.

Parent/Guardian Signature: ______________________________________ Date: ___________________

Parent/Guardian Signature: ______________________________________ Date: ___________________

DUTY TO WARN NOTICE: Norma J. Cruson, M.Ed., NCC, LPC-S, RPT-S is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to Texas law, any evidence of child abuse, elder abuse, or cruelty to animals must be reported to the authorities. If any individual intends to take harmful, dangerous, or criminal action against another individual, or against himself/herself, it is the therapist's duty to report such action or intent.

Parent/Guardian's Signature: ____ Date: ____________________

Parent/Guardian Signature: ____ Date: ___________________

Norma J. Cruson, M.Ed., NCC, LPC-S, RPT-S

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INFORMED CONSENT/PRIVACY PRACTICES/PROFESSIONAL DISCLOSURE

Please be aware you and your child are partly responsible for the outcome of your therapeutic experience. Therapy may open levels of awareness that could cause pain and anxiety. We can address these issues and assist you and your child with coping techniques to effectively process the experience.

Rights and Responsibilities in Psychotherapy

Therapy is a relationship which works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights because this is your therapy, whose goal is your well-being. There are also certain legal imitations to those rights you should be aware of before and during engagement in therapy. A therapist has corresponding responsibilities to you.

I. Confidentiality:

With the exception of certain specific situations described below, you have the right to the confidentiality of your therapy. Your therapist will act to protect your privacy. You may direct your therapist to share information with whomever you choose and you can revoke that permission at any time. The following are exceptions to your right to confidentiality:

1. She may disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person. Any disclosure however, would only be to someone able to help prevent the threatened harm.

2. If she has good reason to believe you are abusing or neglecting a child or vulnerable adult, or if you give her information about someone else who is doing this, your therapist must inform Child Protective Services (child) and Adult Protective Services (adult) within 48 hours.

3. She may use and disclose information about you in order to ensure you receive proper treatment from other mental health and medical providers.

4. She may disclose information about you in a response to a court or administrative order, subpoena, discovery request, or other lawful process, but only if efforts or disclosures have been made to tell you about the request.

5. The State Board, graduate schools, high-security government agencies and so forth may request information concerning services rendered. This information will be forwarded only with your written consent.

6. If you are in individual sessions while undergoing couple's therapy or family therapy, what you say in individual sessions will be considered to be a part of the couple's or family therapy, and can be discussed in joint sessions. Do not tell your therapist anything you wish kept secret from your partner or family members who are in treatment with you.

7. She may release your information under limited circumstances if you are a member of the armed forces or foreign military personnel, or for intelligence, counterintelligence or other national security activities authorized by law.

8. She may use and disclose information about you so to obtain payment for the treatment and services provided to you or to another party for whom you have financial responsibility.

II. Record-keeping

Your therapist keeps brief records, noting you have been here and a few words describing the topics discussed. These files are maintained for five years after your last visit. You have the right to a copy of your file. You have the right to request she make a copy of your file available to any other health care provider at your written request. ***You may not have access to psychotherapy notes or information put together for use in civil, criminal, or administrative proceedings.*** To inspect or copy your information, you must submit your request in writing. If you request a copy of the information, she may charge a fee for the cost of copying, mailing, or other supplies associated with your request. Please allow 10 business days to process the request.

III. Diagnosis

If a third party is paying for part of your bill, your therapist will be required to give a diagnosis to that party in order to be paid.

IV. Other Rights

You have the right to ask questions about anything that happens in therapy. You can ask your therapist about her training for working with your concerns and can request she refer you to someone else if you decide she is not the right therapist for you. You are free to leave therapy at any time.

V. Managed Mental Health Care

If your therapy is being paid for in full or in part by a third party agency there are limitations to your rights a client imposed by the contract of the agency. These may include their decision to limit the number of sessions available to you, decide the time period within which you must complete your therapy, or to require you to use medication. Such firms also usually require some sort of detailed reports of your progress in therapy and copies of your case file.

VI. Your Therapist's Approach to Therapy

Your therapist will use Child-Centered Play Therapy for your child, a non-directive approach that allows the child control of play therapy choices thereby assisting the child in developing autonomy, self-regulation, mood regulation, and an inner locus of control that helps him/her manage daily situations in life. With reflections from the therapist and slight redirections at times to keep the child, therapist, and room safe, the child is responsible for making play choices and allowed to release tension and emotion related to past experiences and current stressors.

Your therapist may propose use of Eye Movement Desensitization Reprocessing (EMDR) to facilitate symptom reduction for your child. If your therapist proposes EMDR or any specific technique that may have special risks attached, she will inform you of that and discuss with you the risks and benefits of what she is suggesting. Your therapist may suggest you consult with a physical health care provider regarding somatic treatments that could help your child's problems. She may suggest you or your child get involved in a therapy or support group as part of your work. You have the right to refuse anything suggested without being penalized in any way.

Approaching feelings or thoughts your child has tried not to think about for a long time may be painful. Making changes in beliefs or behaviors can be scary, and sometimes disruptive to existing relationships. You may find your child's relationship with your therapist to be a source of strong feelings. It is important you consider carefully whether these risks are worth the benefits to your child of changing. Most people who take these risks find therapy is helpful, and your therapist will do what she can to help you minimize risks and maximize positive outcomes.

You have the right to decide when therapy will end with three exceptions. If your therapist has contracted for a specific short-term piece of work, she will normally finish therapy at the end of that contract. If your therapist is not in her judgment able to help you, she is required to inform you of this fact and refer you to another therapist who can meet your needs. She would continue to meet with you until you had established a relationship with a new therapist, and would assist you in finding this person. If you do violence to or harass your therapist, the office, or anyone in her family, she reserves the right to terminate you unilaterally and immediately from treatment.

There may be times when your therapist might consult with professional colleagues to gain insight and feedback. If she does so, she will not use your name or any information that can identify you. If your therapist is away for professional meetings, vacations, etc., she will tell you in advance of planned absences.

VII. Treating Doctor Status

Your therapist is your treating doctor and advocate and cannot be an expert witness in any legal matter in which you may become involved, including any legal issues related to your treatment. A forensic expert must be objective and must not be an advocate.

VIII. Your Responsibilities as a Therapy Client

You are responsible for coming to your session on time, at the time scheduled. If you are late, your session will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours' notice, you must pay for that session at your next regularly scheduled meeting. The only exception to this rule is if you would endanger yourself by attempting to come (e.g., driving on icy roads). All sessions must be paid at the time received.

IX. Complaints

If you are unhappy with what is happening in therapy, you should talk about it with your therapist so she can respond to your concerns. If you believe she has been unwilling to listen or has behaved unethically, you can complain about her behavior to the Texas Board of Licensed Professional Counselors (512) 305-7700. You are free to discuss your complaints about her with anyone you wish and do not have any responsibility to maintain confidentiality about what she does that you do not like since you are the person who has the right to decide what you want kept confidential.

Client/Parent or Guardian Consent to Psychotherapy

I have read this statement, had sufficient time to consider it carefully, asked any questions I needed to ask, and understand the statement. I consent to the use of a diagnosis in billing. I agree to pay my therapist's fee for listed services. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to engage in therapy with Norma J. Cruson, MEd., NCC, LPC, RPT, EMDR Trained. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Norma J. Cruson, MEd., NCC, LPC,RPT, EMDR Trained. I have received a copy of the Informed Consent/Professional Disclosure/Privacy Practices. I am over the age of eighteen years or my parent/guardian must also sign their consent below.

_

____________________________________ ____

Client's Printed Name (or Parent/Guardian) Client's Signature (or Parent/Guardian's Signature) Date

Credit Card Authorization

I hereby grant to Norma J. Cruson, M.Ed., NCC, LPC, Registered Play Therapist, permission to process credit/debit charges.

This form is requested for all clients to be on file.
Client Name/s: ____

Please read all below:
Acceptable forms of payment are: cash, check, debit card or credit card.

My initials below:
______ Without my debit/credit card, I authorize Norma J. Cruson, M.Ed., NCC, LPC, Registered Play Therapist, to use my credit/debit card number provided below to process charges/fees assigned to any named individual listed above.

______ I authorize Norma J. Cruson, M.Ed., NCC, LPC, Registered Play Therapist, to be compensated for missed appointments of which the client/s named above did now show up for session or cancel session less than 24 hours before the time of the appointment.

Missed and last canceled appointment fees are billed at the client's normal counseling session rate.

Please complete all of the information below:
The security of your personal information is extremely important. Norma J. Cruson, M.Ed., NCC, LPC, Registered Play Therapist is committed to protecting the security and privacy of any personal information you provide, including any financial information. Please inquire of any questions concerning this authorization, the "information regarding services" and/or "Notice of Privacy Policy Practices" forms provided for your review and agreement.

Type of card (circle)	Exact name on card	16 Digit Card number	Expiration Date	CVU
VISA MC	__________________________	____________________________	____/______	_______

Billing address associated with this credit card:

Street: ____ Apt. #__________ City: ____________________ Zip ________

Signature ____ Date ______________________

Service	Length of Service	Fee for Service
Parent Consult (w/o child)	50 minutes	$130 cash/check or $135 credit card
Individual Child Session	50 minutes	$130 cash/check or $135 credit card
Individual Adult Session	50 minutes	$130 cash/check or $135 credit card
EMDR 90 minutes, adult	90 minutes	$160 cash/check or $165 credit card
Group Sessions for Child/Adult	50 minutes	$60 per client
Couples Counseling	50 minutes	$160 cash/check or $165 credit card
Letter writing or court preparation of notes	60 minutes	$60 per hour
Insufficient Funds Returned Check		$25
Missed appointment or cancellation with less than 24-hour notice		$130, paid at next appointment