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

I am pleased you are coming to talk with me so you can get more of what you want out of life. For adults I practice a person-centered approach, sometimes using Eye Movement Desensitization Reprocessing (EMDR) as well as incorporating sand tray work when possible. 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, an EMDRIA trained EMDR therapist, a UNT Certified Child-Centered Play Therapist, and a Registered Play Therapist-Supervisor.
- I work with children, adolescents, adults, and families on a variety of issues.
- If you are coming for an EMDR consultation and have another therapist, with your permission I will collaborate with your current therapist.
- 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, 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

Adult Client Information

Today's Date: _____ **Name of Person Completing this Form:**_____
First Name: _____ Middle: _____Last:_____
Date of Birth:____/____/_____Age: _____ Preferred to be called/nickname: _____
Gender: _____Male ___Female Marital Status: ___Single ___Married ___Separated ___Divorced __Widowed
Address: _____ City/State: _____Zip: _____
Home Phone: _____ Alt. Phone #: _____ E-mail: _____
How may I contact you to leave appointment reminders or provide information to you? ___Home ___Cell ___Text __email
Emerg. Contact: Name_____ Phone: _____ Address: _____
Name of person who referred you: _____ Phone: _____

Current and Prior Medical Care:
Are you currently under the care of a physician? Yes____ No____ Doctor's Name: _____
Phone: _____ Address: _____

Have you ever received prior psychological, psychiatric, drug/alcohol treatment or counseling? Yes____ No____
Name and address of provider: _____ Phone: _____
When? _____ For what reason(s)? _____
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: _____

Have you ever taken medications for psychiatric or emotional problems? Yes__ No__: When? _____
What medications? _____ For what reason(s)? _____
Do you take your meds as prescribed? __Yes __Take too much __Don't always take

Family of Origin

	Age/Age at death	Cause of death	Occupation	Education	Relationship (pos. or neg. overall)
Father					
Mother					
Step-parents					
Grandparents					
Uncles/Aunts					
Brothers					
Sisters					

Marital/Significant Relationship History

Name of person	Person's age at beginning	Your age at beginning	Your age at end	Reasons for ending

Children *(indicate which are from a previous relationship with a "P" in the last column)*

Name	Current Age	Gender	School Grade	Adjust. Problems?	P?

Abuse History: If you were 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
N= neglect, such as failure to feed, shelter, or protect or abandonment ***E*** = emotional, such as humiliation, etc.

Your Age	Kind of Abuse	By Whom?	Did you tell?	Consequences of telling

Chemical Use

1. Have you ever felt the need to cut down on your drug usage or drinking? ___Yes ___No
2. Have you ever felt annoyed by criticism of your drug usage or drinking? __Yes ___No
3. Have you ever felt guilty about your drug usage or drinking? ___Yes ___No
4. Are there times you use drugs or drink to unconsciousness? ___Yes ____No
5. Are there times you run out of money as a result of using drugs or drinking? ___Yes ___No

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

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

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

OTHER

Please list any legal issues past or current that are affecting you or your family at present: _____

_____

Have you ever had suicidal thoughts? __Yes __ No Do you currently have suicidal thoughts? ___Yes ___No
Have you ever had thoughts about harming others?__ Yes __No Have you ever attempted suicide? ___Yes ___No

Adult Checklist of Concerns

Please describe the main difficulty that brought you to see me_____
What have you done to try to manage your presenting concerns or problems?_____
Please mark any of the following that apply. You may add a note or details in the space next to the concern.

( ) I have no concern bringing me here.
( ) Abuse of others (children, animals, adults)-physical, sexual, emotional, neglect
( ) Abuse suffered from others-physical, sexual, emotional, neglect
( ) Aggression, violence
( ) Alcohol use
( ) Anger, arguing, hostility, irritability
( ) Anxiety, nervousness
( ) Attention, concentration, distractibility
( ) Career change, boredom, unfulfilling
( ) Childhood issues (your own childhood)
( ) Confusion
( ) Compulsions
( ) Custody of children
( ) Decision-making, indecision, mixed feelings, putting off decisions
( ) Delusions
( ) Dependence
( ) Depression, low mood, sadness, crying
( ) Divorce, separation
( ) Drug use---prescription medications, over-the-counter medications, street drugs
( ) Eating problems---over-eating, under-eating, appetite issues, vomiting
( ) Emptiness
( ) Failure
( ) Family issues
( ) Fatigue, tiredness, low energy
( ) Fears
( ) Financial or money troubles, debt, impulsive spending, low income
( ) Flashbacks
( ) Friendships
( ) Gambling
( ) Grieving, mourning, deaths, losses, divorce
( ) Guilt
( ) Headaches, other kinds of pain
( ) Health, illness, medical concerns, physical problems
( ) Housework/chores-quality, schedules, sharing duties
( ) Inferiority feelings
( ) Impulsiveness, loss of control, outbursts
( ) Intrusive thoughts
( ) Irresponsibility
( ) Isolation
( ) Judgment problems, risk-taking
( ) Legal matters, charges, suits
( ) Loneliness
( ) Marital conflict
( ) Media addiction---internet, video games, television
( ) Memory problems
( ) Mood swings
( ) Motivation, laziness
( ) Nervousness, tension
( ) Obsessions, compulsions
( ) Oversensitivity to rejection
( ) Panic or anxiety attacks
( ) Parenting, child management, single parenthood
( ) Perfectionism
( ) Phobias
( ) Procrastination
( ) Relationship issues
( ) Self-centeredness
( ) Self-esteem
( ) Self-neglect, poor self-care
( ) Shyness, oversensitivity to criticism
( ) Sleep problems
( ) Spiritual, religious, moral, ethical issues
( ) Stress, relaxation, stress management
( ) Suspiciousness
( ) Suicidal thoughts
( ) Temper problems, low frustration tolerance
( ) Thought disorganization and confusion
( ) Tobacco use
( ) War-related trauma
( ) Withdrawal, isolating
( ) Work issues

Any other issues or concerns: _____
Please choose your top concern of the ones listed above: _____

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INFORMED CONSENT/PRIVACY PRACTICES/PROFESSIONAL DISCLOSURE

You 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 with coping techniques to effectively process the experience.

Rights and Responsibilities in Psychotherapy

Your Rights as a Therapy Client

The therapeutic relationship works in part because of clearly defined rights and responsibilities held by each person. This framework helps 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 limitations to those rights you should be aware of before and during engagement in therapy. A therapist has 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 always act so as 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. Your therapist may disclose information about you when/if:

1. …necessary to prevent a serious threat to your health and safety or the health and safety of another person. Disclosure would only be to someone able to help prevent the threatened harm.

2. …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. …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.

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

5. …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/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.

6. …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.

7. …needing 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 working days for her 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 further 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 a person-centered approach sometimes combined with sand tray processing to assist you in developing more regulation of mood, reduction of anxiety, lessening of depressive moods and thoughts, and thereby attempting to create an internal locus of control and a sense of well-being for you such that you can better manage your daily living. Your therapist will examine with you possibly your past experiences as well as current stressors to help you live a more emotionally and cognitively balance life.

On occasion, with particular traumas and phobias, your therapist may propose use of Eye Movement Desensitization Reprocessing (EMDR) to facilitate symptom reduction. 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 you. She may suggest you become 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 you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to your current relationships. You may find your 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 you for 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.

Client 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-S, RPT-S, 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-S, RPT-S, EMDR Trained. I have received a copy of the Informed Consent/Professional Disclosure/Privacy Practices.

_____ _____

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

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Credit Card Authorization

I hereby by grant to Norma J. Cruson, M.Ed., NCC, LPC-S, RPT-S, 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-S, RPT-S, 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-S, RPT-S, 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-S, RPT-S 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	CVC
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
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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

_____
Client's Printed Name

_____ _____
Client's Signature Date