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

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

Child As Client Intake Information Form

I am pleased you are bringing your child to work with me. For children ages 2 1/2 to 11 years, I utilize Child-Centered Play Therapy. 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 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.
- All child client services begin with a 50-minute parent consult (without the child present). Thereafter, child clients meet in individual weekly sessions for 50 minutes with their therapist. Parents are encouraged to meet with their child's therapist after every three to five of the child's sessions for further consults.

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

CHILD 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)*

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)

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: _____

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

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	

CONSENT FOR TREATMENT OF A MINOR CHILD

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-S, RPT-S 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: _____

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 or elder abuse 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 may be the therapist's duty to report such action or intent.

Parent/Guardian's Signature: _____ Date: _____

CHILD CHECKLIST OF CHARACTERISTICS

Child: _____ Date: ____/_____/_____
Child's Age: _____Person completing this form: _____ Relationship: _____
If you brought a child for evaluation or treatment, please review this checklist which contains concerns (as well as positive traits) and mark items that describe your child.

___Affectionate
___Argues, "talks back", defiant
___Boasts and brags
___Bowel problems (constipation, frequently loose, irregular)
___Bullies/intimidates, teases, inflicts pain on others, is bossy, picks on, provokes
___Carries a chip on his/her shoulder
___Cheats
___Cruel to animals
___Concern for others
___Conflicts with parents over rules, money, chores, homework, grades, choices in music/clothes/hair/friends
___Complains
___Cries easily, feelings easily hurt
___Dawdles, procrastinates, wastes time
___Denies mistakes or blames others
___Dependent, immature
___Developmental delays
___Difficulties with parent's new relationship/new marriage/new family
___Disrupts family activities
___Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
___Distractible, inattentive, poor concentration, daydreams, slow to respond
___Disturbs other children
___Dropping out of school
___Drug or alcohol use
___Easily frustrated, irritable
___Eating---refuses food, appetite increase or decrease, odd combinations, overeats
___Excitable, impulsive
___Extracurricular activities interfere with academics
___Fails to finish things
___Failure in school
___Fearful
___Feels cheated in family circle
___Fighting, hitting, violent, aggressive, hostile, threatens, destructive
___Fire setting
___Friendly, outgoing, social
___Headaches
___Hypochondriac, always complains of feeling sick
___Immature, "clowns around", has only younger playmates
___Imaginary playmates, fantasy
___Independent
___Interrupts, talks out, yells
___Lacks organization, unprepared
___Lacks respect for authority, insults, dares, provokes, manipulates
___Learning disability
___Legal difficulties
___Lets self be pushed around
___Lies
___Likes to be alone, withdraws, isolates
___Moody
___Mute, refuses to speak
___Nail biting
___Need for high degree of supervision at home over play/chores/schedule
___Nervous
___Nightmares
___Obedient
___Oppositional, resists, refuses to comply, negativism
___Other aches or pains
___Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
___Picks at things (nails, fingers, hair, clothing)
___Pouts/sulks
___Problems sleeping
___Problems with making or keeping friends
___Recent move, new school, loss of friends
___Relationships with brothers/sisters or friends/peers are poor—-competition, fights, teases, provokes, assaults
___Responsible
___Restless in the "squirmy" sense
___Restless, always up and on the go
___Rocking or other repetitive activities
___Runs away
___Sad, unhappy
___Self-harming behaviors---biting or hitting self, head banging, scratching self, cutting self
___Sexual---sexual preoccupation, public masturbation, inappropriate sexual behaviors
___Shy, timid
___Speaks differently than others same age (baby talk, stuttering, hard to understand)
___Speech difficulty
___Steals
___Stomachaches and pains
___Stubborn
___Suicide talk or attempt
___Swearing
___Temper tantrums, rages
___Thumb sucking, finger sucking, hair chewing
___Tics---involuntary rapid movements, noises, or word productions
___Teased, picked on, victimized, bullied
___Truant, school avoiding
___Uncoordinated, accident-prone
___Underactive, slow-moving, or slow-responding, lethargic
___Vomiting or nausea
___Wants to run things
___Wetting or soiling the bed or clothes

ANY OTHER CHARACTERISTICS:

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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 your child in processing 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 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:

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. 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 or your child are abusing or neglecting a child or vulnerable adult, or if you or your child give her information about someone else who is doing this, your therapist must inform either Child Protective Services or Adult Protective Services 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/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 your 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 may require 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. Your child is responsible for making play choices and allowed to release tension and emotion related to past experiences and current stressors.

With particular traumas and phobias, 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 the relationships he/she already has. 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 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 third party 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. 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

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Child-Centered Play Therapy Information

Child-Centered Play Therapy (CCPT) is appropriate for children ages 2 ½ to about 11 years of age as children do not have the ability to identify and describe their own complex emotional states. In CCPT we say "play is the child's language" and "toys are the child's words". CCPT is a non-directive approach that allows the child control of play choices thereby assisting the child in developing autonomy, self-regulation, and an inner locus of control that helps him/her manage daily situations in life.

The following information should help you facilitate your child having successful therapeutic sessions:

1. Before the initial session, tell your child he/she is going to visit "Norma" to "talk about whatever you want to talk about". Your child sets the session's agenda as he/she is the one who is feeling the emotions and living the concerns. If your child insists on knowing more, you might say, for example, "I have noticed you have some problems with ___, and Norma is someone who can help." It usually helps if you tell them I have "lots of toys" and help children with their problems.

2. Prepare your child for each session by ensuring they have had enough to eat before hand, are not sleepy, have used the restroom facilities, etc. We likely need to reschedule your child if he/she is ill.

3. Your child should leave personal toys, games, videos at home as they won't be needed in the playroom.

4. You might not want them to wear that new shirt or shoes as sometimes we like to paint or play in the sand (I do use paint shirts and washable materials, but just in case…).

5. I will focus entirely upon your child. It is his/her special time and we don't want your child having that "grown-ups-are-talking-about-me" feeling. However, I value your input and feedback as it can help me help your child, so we can make appointments for either in-person or via phone to talk about special concerns. Ideally, we would schedule a parent consult after every three to five sessions, if possible. I will also quietly provide you a weekly "Parent Summary" in the waiting room that you can complete while your child is in session. Just hand the completed form quietly to me after the session.

6. Please don't ask your child, "so did you have fun?" or "what did you do?" as the session is confidential. Your child may share on his/her own time what the session was like. Often they will say, "I wanna come back" or "we just played". "We just played" is true! It would be the same as an adult replying, "We just talked".

7. Your child may start repeating my tracking comments at home, which is wonderful! This means they are internalizing these positive statements! I will be tracking your child's play with comments like: "sometimes that happens in here", "you know how to do that". These are opportunities at home to validate the new phrases by either repeating back the phrase to the child or by simply noticing the comment.

8. If your child brings a drawing, painting, sculpture, etc., from the playroom, you are going to want to refrain from making value statements. It is difficult to not say, "how beautiful", but these statements can negatively emphasize that play therapy is an opportunity to gain attention. You will want to stay with simple, true comments such as "you made that for me."

9. While CCPT often provides immediate relief to children, it is also usually a long-term, weekly process. Children initially seem to immediately experience delight and relief they can share their concerns. However, going deeper into the concerns, your child will at times suddenly feel emotions not yet seen in therapy or at home or school. This is generally part of the "working through" process.

I hope this helps and I look forward to working with you and your child. This is an opportunity to help a young person feel more inner calm, healthy control, self-direction, self-monitoring, and release of tension and emotion related to his/her concerns.

Sincerely,

Norma J. Cruson, M.Ed., NCC, LPC-S, RPT-S
Certified Child-Centered Play Therapy Clinician
EMDRIA Trained EMDR Clinician

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

I hereby 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.
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	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

Thank you!