GENE KUMMERER II, MS, MDIV, LPC-S

4425 SOUTH MOPAC EXPRESSWAY
BUILDING IV, SUITE 700
AUSTIN, TEXAS 78735
(512) 897-4787 – OFFICE

www.genekummerer.com

Consultation Information Sheet (Child)

Child's Name: _____ Date of Birth: _____Age: _____

Home Address: _____ Home Phone:_____
Street: City: State: Zip:

Marital Status of Parents: Married ☐ Divorced ☐ Separated ☐

Father's Name: _____Age: _____

Father's Address (if different from child) _____Home Ph_____

Father's Work Phone: _____Cell: _____ E-mail: _____

Where Employed: _____Occupation:_____

Mother's Name: _____Age:_____

Mother's Address (if different from child) _____Home Ph _____

Mother's Work Phone: _____Cell: _____ E-mail: _____

Where Employed:_____Occupation:_____

Stepfather's Name: _____Age: _____

Stepmother's Name: _____Age: _____

Emergency Contact other than parents:

Name:_____Address:_____

Home Phone:_____Cell:_____Relationship to Child: _____

Church You Attend: _____

How did you hear about Gene? Please include name of the person who referred you (if applicable).

☐ Gene's website ☐ Conference or Seminar _____
☐ Friend/Family _____ ☐ M.D./Counselor _____
☐ Pastor _____ ☐ Other _____

(OVER)

Child's brothers and sisters by age (please include step and/or half brothers and sisters):

1. _____ Age: _____ 4. _____ Age: _____

2. _____ Age: _____ 5. _____ Age: _____

3. _____ Age: _____ 6. _____ Age: _____

Names of people living in the home with the child:

_____

Child's School: _____ Grade: _____ Teacher's Name: _____

Please describe the specific problem/concern that has caused the child to come to counseling at this time? _____

_____

What have you done about the problem to this point? _____

_____

Please list any pastor, counselor, therapist or psychiatrist with whom child has previously counseled? Please list dates.

_____

Please list any medications the child is currently taking and name of prescribing physician for each medication: ___

_____

Child's physical health: ☐ Good ☐ Average ☐ In Crisis

Child's Physician: _____ Phone: _____

Recent weight changes: _____ Lost # lbs. _____ Gained # lbs. Date of last physical exam: _____

Has child ever been admitted to a psychiatric hospital? ☐ Yes ☐ No Dates: _____

Hospital: _____ Location: _____

How would you rate child's parents' current marriage?

❑ Very Happy ❑ Happy ❑ Average ❑ In Conflict ❑ N/A

Agreement

I understand that all statements made by me or my child to my counselor are of a confidential nature and generally, except as noted below, may not be disclosed by my counselor without my consent. I further understand and accept as a condition of receiving counseling, that certain statements made by me, by my child or certain situations may require my counselor to take action or make disclosure when my counselor believes it is necessary for the protection of life or when my counselor may be required by law to disclose or report threats or past instances of harm to myself, or threatened harm or past instances of harm to a third person. These disclosures will be made at the sole discretion of my counselor.

_____ _____

Signature of Parent or Guardian of Child Date

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Privacy Policies

This notice describes how psychological and health information about you may used and disclosed, and how you can get access to it. Please review it carefully. **Your privacy is important to me!**

I may use or disclose your health information:

1. to a physician or therapist providing treatment to you.
2. to obtain payment for services I provide to you.
3. in connection with our healthcare operations, including assessment, audits/administrative services, case management and care coordination.

You have the following rights concerning the use/disclosure of your health information:

1. to request restrictions on certain uses and disclosures
2. to inspect and copy your information (excluding psychotherapy notes)
3. to request to amend the information

As required by law, we may use/disclose your health information without your consent or authorization in the following circumstances:

1. Child Abuse
   If we have cause to believe that a child has been or may be, abused or neglected—we are required to report this within 48 hours to the proper authorities.

2. Elderly/Disabled Persons Abuse
   If we have cause to believe that an elderly or disabled person has been or may be abused, neglected, or exploited—we are required to report it to the Department of Protective and Regulatory Services.

3. Judicial/Administrative Proceedings
   If you are involved in a court proceeding which involves a court order requiring information about your diagnosis and treatment.

4. Serious Threat to Health/Safety
   If we determine that you pose a serious threat to yourself or someone else, we may disclose relevant mental health information to medical or law enforcement personnel.

If you have any questions or concerns regarding this notice or your privacy, please do not hesitate to ask me.

_____ _____

Signature Date

GENE KUMMERER, LLC

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Financial Policies

The following information is intended to acquaint you with the financial policies of this practice. Please read it carefully and feel free to discuss any questions you may have.

Counseling sessions are scheduled for sixty (60) minutes. Longer sessions or sessions held more or less often than once per week will be decided on an individual basis.

The initial intake session fee is $175.00. The regular counseling fee is $130.00 per session. Payment is due at the time of the session (unless other arrangements are made in advance). Court testimony fee is $275.00 per hour. Court preparation is $150 per hour. Estimated court fees must be paid prior to services being rendered.

The fee for each session is ***due and payable on the day of the session***. A **no show fee** of $65 will be charged for **missed appointments** that have not been canceled at least **24 hours in advance** of your scheduled appointment. After hours you may leave a message on the voicemail at the office phone number (512) 897-4787.

You are responsible for payment of fees incurred regardless of insurance coverage. While I may offer courtesy billing on a case-by-case basis I cannot accept final responsibility for collecting fees from your insurance company or for negotiating settlements of claims. In the event of an overpayment by an insurance company, a full refund of the overpayment will be made to you.

I have read and understand these financial policies.

_____ _____
Client (or parent/guardian of minor child) Date

_____ _____
Gene Kummerer for ***Gene Kummerer, LLC*** Date

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AUSTIN, TEXAS 78735 (512) 897-4787

Information and Consent Form

Welcome. The following is to ensure that you understand our professional relationship and my qualifications.

Professional Qualifications and Affiliations

- **Master of Science, Educational Psychology: Agency Counseling**, Texas A&M University, College Station, TX
- **Master of Divinity**, Gordon-Conwell Theological Seminary, South Hamilton, Massachusetts
- **Twenty five years of experience** in counseling and social work
- **Licensed Professional Counselor** by the Texas State Board of Examiners of Professional Counselors
- Member **American Association of Christian Counselors; Christian Counselors of Texas; EMDRIA**

Counseling Philosophy & Expectations

I am committed to providing professional counseling guided by the Christian scriptures and informed by psychological research. In sessions I will listen, explain, pray with you, and give homework. Your responsibility is to be open and honest, to complete homework assignments, and to work diligently toward the goals which we establish for your counseling. I expect that, during our counseling relationship, you will be in fellowship with a local church. As a client you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. While benefits from counseling are expected, specific results are not guaranteed. Together we will work to achieve the best possible results for you. You have the right to discuss or refuse any counseling techniques that you believe might be harmful. Sessions are approximately 60 minutes in length. In serious after hours emergencies please contact Shoal Creek Psychiatric Hospital at (512) 324-2000.

If you are ever dissatisfied with my services, please let me know so that I can work with you to resolve your concern. If we cannot resolve your complaint about my services to your satisfaction, you may contact:

Texas State Board of Examiners of Professional Counselors
1100 West 49th Street, Austin, TX 78756
(512) 834-6658

or call:
Consumer Complaint Line
1-800-942-5540

Counseling Confidentiality

What you say to me and records kept regarding your counseling will be held in strict confidence by me and anyone working for me. The clinical records of your treatment will be maintained in my custody for at least the time frames required by law. The following are the most common exceptions to confidentiality. I am ethically and/or legally obligated to disclose information given in confidence:

1. If I have reason to believe that: You are likely to harm yourself or someone else; Abuse or neglect of children, the elderly, or disabled has occurred or is suspected; Someone is planning to harm you or someone else; You have been the victim of previous sexual misconduct by a mental health provider.
2. When a court or administrative proceeding is initiated against me or a court of law issues a subpoena and/or orders me to disclose information, which may include your written records.
3. When disclosure of your identifying information (name, birth date, social security number, address, etc.), diagnosis, dates of service and charges, and progress is required by your insurance company, third party payer, or a collection agency to collect unpaid fees.
4. When you are involved in group, marriage, or family counseling--it is impossible to guarantee that members will not disclose what happens in the session to non-members.
5. When counseling children under 18—parents, however, are encouraged to respect their child's confidentiality.
6. When I engage in supervision/ consultation to ensure the quality of services that I provide.
7. If you remain sexually active after being informed that you have a sexually transmitted disease, and are potentially spreading the disease, I have a responsibility to act to protect those you might put at risk.

Plan for Custody and Control of Mental Health Records

In the event of my death or incapacity or the termination of my counseling practice, the records of your mental health treatment will be transferred to the custody and control of Dr. Samuel Adams. Dr. Adams may be reached at (512) 328-9700. His offices are located at 4425 S Mopac Expy #700, Austin, TX 78735.

Client Understanding and Consent

Your signature below means that you have given me permission to counsel you (and/or your child) according to biblical principles, and that all of the above criteria and exceptions to confidentiality are understood by you, and accepted freely by you, as they apply to the counseling process.

_____ _____

Client (or Parent/guardian of minor client) Date