D. Scott Stanley, MS, LMFT, LPC

1458 Campbell Road · Suite 250
Houston, Texas 77055
Phone: 281-960-3991
Email: mftshrink@yahoo.com

Thank you for choosing me for your psychological health-care. I assure you that I will work with you in a caring and professional manner. Please take a few moments to read my policies and do not hesitate to ask any questions you may have.

OFFICE HOURS
My office hours fluctuate with my appointments. I will work with you to schedule a mutually agreeable time.

SESSIONS
Full sessions are 50 minutes and half sessions are 25 minutes long. In order to ensure that your time is respected and waiting time does not interrupt your schedule or mine, every effort is made to start and stop on time. Extended sessions can be arranged when necessary. Group sessions are typically 1 ½ hours.

CANCELLATIONS
There is no charge for missed appointments ***if appointments are cancelled at least 24 hours in advance.*** If the appointment is for Monday, the cancellation may be made by leaving a message with the answering service. ***You will be charged for appointments not cancelled 24 hours in advance.***

EMERGENCY SERVICES
Emergency consultation is provided 24 hours each day, seven days a week. I will usually be available to assist you personally. If I am unavailable, you may be referred to one of my colleagues. You may reach me at 281-960-3991. Should I be unavailable for calls, you will be given instructions regarding whom to call. If the consultation requires more than 15 minutes, you may be billed for time.

NOTICE OF PRIVACY PROCEDURES
I am required to: maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information I collect and maintain about you, abide by the terms of this notice, notify you if I am unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

FEES
Payment is due at the time service is rendered. If you are a member of an insurance company for which I am a contracted provider, the feel will be your mental health co-pay. For those patients that belong to an insurance company with whom I am not contracted, I will give you an itemized statement so you may file it with your insurance company and have them reimburse you directly. **Please be advised that if your insurance company does not uphold your contract for any reason, you will be responsible for 100% of incurred charges.**

It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge on the outstanding balance.

TYPES OF THERAPY
A variety of therapies are available depending on your needs and wishes. At your first visit, you and I will evaluate together what issues you wish to address and the type of therapy that would be most appropriate.

Please check each type of therapy you feel may be appropriate.

_____ Marriage or Relational Counseling

_____ Individual Counseling

_____ Parent Consultation

_____ Family Therapy

My goal is that we will develop a positive, rewarding relationship. At this time, please take a few minutes to fill out the enclosed information so that I may better help you achieve your goals.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE OFFICE POLICIES.

_____
Client Signature and Date

If the client is a child, this form must be signed by the legal parent or guardian.

D. Scott Stanley, MS, LMFT, LPC

1458 Campbell · Suite 250
Houston, Texas 77055
281-960-3991
mftshrink@yahoo.com

Consent to Treatment of a Child

Name of child client: _____

The therapist named below and I have discussed my child's situation. I have been informed of the risks and benefits of several different treatment choices. The treatment chosen includes these actions and methods:

1.
2.
3.

These actions and methods are for the purposes of:

1.
2.
3.

I have had the chance to discuss all of these issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist (or another professional, as he or she sees fit) permission to begin this treatment, as shown by my signature below.

_____ _____
Signature of parent/guardian Date

I, the therapist, have discussed the issues above with the child's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

_____ _____
Signature of therapist Date

___ Copy accepted by parent/guardian ___ Copy kept by therapist

D. Scott Stanley, MS, LMFT, LPC

1458 Campbell Road · Suite 250
Houston, Texas 77055
Phone: 281-960-3991
Email: mftshrink@yahoo.com

Patient Information Sheet

Date: _____

Patient's Name: _____ Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Gender: _____

Referred by: _____

Mother's Name: _____
Employer: _____
Work Phone: _____ Driver's License No. _____

Father's Name: _____
Employer: _____
Work Phone: _____ Driver's License No. _____

If appropriate
Which parent has legal custody: _____
Stepmother's name: _____ Phone: _____
Stepfather's name: _____ Phone: _____

Responsible party: _____
Relationship to patient: _____

Primary Insurance

Name of insured party: _____ Date of Birth: _____
Insured's I.D.#: _____ Group #: _____
Insurance Company: _____
Insurance Address: _____
Insurance Phone: _____

I, the undersigned, accept financial responsibility for payment of all fees at the time of visit. Authorization to release information: I hereby authorize the release of any information regarding my child's condition or treatment to my insurance company.

_____
Signature and Date

D. Scott Stanley, MS, LMFT, LPC

1458 Campbell Road · Suite 250
Houston, Texas 77055
Phone: 281-960-3991
Email: mftshrink@yahoo.com

Child Checklist of Characteristics

Name: _____ Date: _____

Age: _____ Person completing this form: _____

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first please mark all of the items that apply to your child on this list. Feel free to add any others at the end under "Any other characteristics."

- ☐ Affectionate
- ☐ Argues, talks back, smart-alecky, defiant
- ☐ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ☐ Cheats
- ☐ Cruel to animals
- ☐ Concern for others
- ☐ Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/friends
- ☐ Complains
- ☐ Cries easily, feelings are easily hurt
- ☐ Dawdles, procrastinates, wastes time
- ☐ Difficulties with parents paramour/new marriage/new family
- ☐ Dependent, immature
- ☐ Developmental delays
- ☐ Disrupts family activities
- ☐ Disobedient, uncooperative, refuses, noncompliance, doesn't follow rules
- ☐ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ☐ Dropping out of school
- ☐ Drug or alcohol use
- ☐ Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ☐ Exercise problems
- ☐ Extracurricular activities interfere with academics
- ☐ Failure in school
- ☐ Fearful
- ☐ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ☐ Fire setting
- ☐ Friendly, outgoing, social
- ☐ 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, provokes, manipulates
- ☐ Learning disability
- ☐ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ☐ Likes to be alone
- ☐ Lying
- ☐ Low frustration tolerance, irritability
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Nervous
- ☐ Nightmares
- ☐ Need for high degree of supervision at home over play, chores/schedule
- ☐ Obedient
- ☐ Obesity
- ☐ Overactive, restless, hyperactive, out-of-seat behaviors, fidgety, noisiness
- ☐ Oppositional, resists, refuses, does not comply, negativism
- ☐ Prejudiced, bigoted, insulting, name calling, intolerant
- ☐ Pouts
- ☐ Recent move, new school, loss of friends
- ☐ Relationships with siblings or friends/peers are poor—competition, fights, teasing/provoking
- ☐ Responsible
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad, unhappy
- ☐ Self-harming behaviors, biting or hitting self, head banging, scratching self
- ☐ Speech difficulties
- ☐ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ☐ Shy, timid
- ☐ Stubborn
- ☐ Suicide talk or attempts
- ☐ Swearing, bathroom language, foul language
- ☐ 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
- ☐ Underachieving, slow-moving, or slow-responding, lethargic
- ☐ Uncoordinated, accident-prone
- ☐ Wetting or soiling the bed or clothes
- ☐ Work problems, employment, workaholism, overworking, can't keep a job

Any other characteristics:

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it?

_____

_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

D. Scott Stanley, MS, LMFT, LPC

1458 Campbell Road · Suite 250
Houston, Texas 77055
Phone: 281-960-3991
Email: mftshrink@yahoo.com

Child Developmental History Record

A. Identifications

1. Child's name:_____ Birthdate:_____ Age:_____
   Person(s) completing this form: _____ Today's date: _____
2. Mother's name:_____ Birthdate:_____ Home phone:_____
   Address: _____
   Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____
3. Father's name:_____ Birthdate:_____ Home phone:_____
   Address: _____
   Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____
4. Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other:_____
   Child's custodian/guardian is: _____
5. Stepparent's name:_____ Birthdate:_____ Home phone:_____
   Address: _____
   Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____

B. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery
   Prenatal medical illnesses and health care: _____
   _____
   _____
   Was the child premature? _____ Weight and height at birth: _____ _____
   Any birth complications or problems? _____
   _____
   _____

2. The first few months of life
   Breast-fed? If so, for how long? _____
   Any allergies? _____

(cont.)

Sleep patterns or problems: _____

_____

_____

Personality: _____

_____

_____

3. Milestones: At what age did this child do each of these?

Sat without support: _____ Crawled: _____

Walked without holding on: _____ Helped when being dressed: _____

Ate with a fork: _____ Stayed dry all day: _____

Didn't soil his or her pants: _____ Stayed dry all night: _____

Tied shoelaces: _____ Buttoned buttons: _____

4. Speech/language development

Age when child said first word understandable to a stranger: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? _____

_____

_____

C. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

(cont.)

D. Residences

1. Homes

Dates					
From	To	Location	With whom	Reason for moving	Any problems?

2. Residential placements, institutional placements, or foster care

Dates				
From	To	Program name or location	Reason for placement	Problems?

E. Schools

School (name, district, address, phone)	Grade	Age	Teacher

May I call and discuss your child with the current teacher? ❑ Yes ❑ No

F. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.: _____

_____

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

_____

_____

_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

D. Scott Stanley, MS, LMFT, LPC

1458 Campbell · Suite 250
Houston, Texas 77055
281-960-3991
mftshrink@yahoo.com

Agreement for Parents

Psychotherapy can be a very important resource for children of separation and divorce. Establishing a therapeutic alliance outside of the home can:

- Facilitate open and appropriate expression of the strong feelings which routinely accompany family transitions, including guilt, grief, sadness and anger.
- Provide an emotionally neutral setting in which children can explore these feelings.
- Help children understand and accept the new family composition and the plans for contact with each member of the family.
- Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

However, the usefulness of such therapy is extremely limited when the therapy itself becomes simply another matter of dispute between parents. With this in mind, and in order to best help your child, I strongly recommend that each of the child's caregivers (e.g., parents, stepparents, daycare workers, *guardian ad litem* [GAL]) mutually accept the following as requisites to participation in therapy.

1. As your child's psychotherapist, it is my primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician, should matters of your child's physical health be relevant to this therapy.

2. I ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite each of you to initiate frequent and open exchange with me as your child's therapist.

3. I ask that all parties recognize and, as necessary, reaffirm to the child, that I am the child's helper and not allied with any disputing party.

4. I strongly recommend that all caregivers involved choose to participate in psychoeducational groups in which separating and divorced parents learn basic strategies for conducting a divorce in the best interests of the child. I can refer you to such programs.

5. Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child in these circumstances:

- I keep records of all contacts relevant to your child's well-being. These records are subject to court subpoena and may, under some circumstances, be solicited by parties to your divorce, including your attorneys.
- Any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to my attention that are irrelevant to the child's welfare may be kept in confidence. However, these matters may best be brought to the attention of others, such as attorneys, personal therapists or counselors.
- **I am legally obligated to bring any concern regarding the child's health and safety to the attention of relevant authorities. When possible, should this necessity arise, I will advise all parties regarding my concerns.**

D. Scott Stanley, MS, LMFT, LPC

1458 Campbell · Suite 250
Houston, Texas 77055
281-960-3991
mftshrink@yahoo.com

6. This psychotherapy will not yield recommendations about custody. In general, I recommend that parties who are disputing custody strongly consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than try to settle a custody dispute in court.

7. Payment for my services is due, in full, at the time of service in a manner agreed to by all parties involved. Any outstanding balance accrued (for example, in conference with attorneys, the GAL, or teachers), must be paid promptly and in full. An initial retainer of $_____ will be required prior to commencing this therapy to be held against charges incurred and subject to reimbursement at the conclusion of this therapy, as appropriate.

Your understanding of these points and agreement in advance of starting this therapy may resolve difficulties that would otherwise arise and will help make this therapy successful. Your signature, below, signifies that you have read and accept these points.

_____ _____
Caregiver name Date

_____
Printed name

_____ _____
Caregiver name Date

_____
Printed name

_____ _____
Caregiver name Date

_____
Printed name

_____ _____
Caregiver name Date

_____
Printed name

_____ _____ _____
Child's name Date of birth Age