Alice Baland, MA, LPC, RDN

Psychotherapist, Dietitian, Hypnotherapist

214-335-5556 (cell)

Welcome to my office, health and life skills program! I'm glad that you are here, and I am committed to providing you with quality care for your specific concerns and interests.

Therapy is a relationship between people that works, partly, because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take appropriate risks and the support to become empowered to change. As a client in psychotherapy or counseling, you have certain rights that are important for you to know. This is your therapy (or your child's), and the goal is your well-being. Following are certain legal limitations to those rights of which to be aware. As your therapist I have corresponding responsibilities to you.

Trust and openness are essential for effective therapy. Confidentiality is carefully protected. Expert consultation may at times be provided me on your case by trusted specialists as needed. This adds value and perspective to your sessions. Otherwise, the matters discussed in therapy are not discussed with anyone without your specific permission. Disclosure may be mandated in the following situations for your safety or that of your child's:

1. If there is a risk of imminent serious harm to yourself or others.
2. If your records are subpoenaed.
3. If the information is requested by your insurance company.
4. If you report neglect or abuse of a minor.
5. If you report sexual misconduct of a physician or therapist.

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've chosen a certain treatment, and often we will create a personal solution together. Please feel free to ask me to try alternatives you think might be helpful. I use a variety of therapies and skills, each personalized to you as an individual. These may include, but are not limited to: dialogue, family systems, cognitive behavioral, positive psychology, nutrition, cognitive reframing, self-monitoring, awareness activities, art therapy, hypnotherapy, EFT (Emotional Freedom Technique, similar to EMDR), visualization, journaling, drawing, reading books, listening to audio programs, keeping food and mood records, etc. Therapy also has potential emotional risks. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to relationships in which you are engaged. Most people who take these risks find that therapy is helpful. I'll do what I can to minimize risks and maximize positive outcomes for you. You have the right to refuse anything I suggest without being penalized in any way. I do not engage in any social, sexual, or business relationships with clients or former clients, because not only would that be unethical and illegal, but an abuse of power. I value our professional therapy relationship too much.

The **initial assessment is 90 minutes** and is **$250** (see Free Gifts on last page). A regular therapy session is **45 minutes** and is **$150.00** per session or **60 minutes** for **$200.00**. For those who travel from out-of-town, or wish more rapid treatment, I have 90 minute sessions available for $300 a session. In addition, I offer customized packages for weight management, disordered eating, anxiety and other conditions, which I will personalize to fit your situation. I also offer half-day family sessions. Just ask. **Payment is due at the time of treatment.** I accept Visa, MasterCard, check and cash. Receipts are available if you wish to file with a claim form to your insurance company. I am an out-of-network provider. Please remember that I specialize in disordered eating, weight management, stress, anxiety, PTSD, trauma, mood and depressive disorders as BOTH a psychotherapist AND a dietitian. You get the expertise of both from a whole person, whole health perspective.

Please CALL my **VOICE MAIL** at **214-335-5556 at least 24 hours in advance during the week and by 9 AM on Friday for a Monday appointment should you need to cancel or change your appointment. This time is reserved just for you.** Otherwise you will be charged the full fee, for which insurance does not reimburse. This policy is in effect regardless of the reason for cancellation. However, an added benefit is that if you are sick, stuck in traffic, or have an emergency, we can do a phone session instead. Phone coaching is $50.00 per quarter hour segment (6-15 minutes) **or** for the time allotted for your session, usually 45 minutes. [There is no charge for calls less than 5 minutes/month.] Arriving late for a session still requires ending at the scheduled time and paying the full fee, so that I may prepare for the

next client. Lengthening a session will be charged by the quarter hour, if time is available. There is a $30.00 charge for returned checks. If you are having a hard time paying, please tell me so we can discuss options. Should an invoice have to be sent, there is a $15.00 administrative fee, plus a $25 per month late fee, and this increases the cost of your service. [Note: No social media requests please for confidentiality.]

SHOULD YOU REQUEST MY TIME for COURT APPEARANCES, preparing reports, attorney or psychology consults, photocopies, or anything else, IT IS $200 per hour, portal to portal, by phone or in-office, paid in advance by you. Email is **not** the preferred method to cancel or change appointments unless we have discussed this in advance, since I usually do not have my computer with me. **Please call or text me at 214-335-5556** to change appointments or let me know that you are running late. Call me 24 hrs. in advance to avoid being charged full fee. No therapy by text please for confidentiality purposes. Thank you!

I have a separate agreement for LIFE/BUSINESS COACHING, which is available for clients by phone and email nationwide along with teleclasses. Clients sometimes transfer to this after improvements in therapy or counseling.

I will be happy **to call** or send a progress note to your health care provider or therapist to facilitate a more unified approach to your care. Please complete the information below if you consent and allow me to release or receive *specific* information to the following relative to treatment and/or assessment. Please PRINT and fill in the name of your:

Therapist_____ Phone_____
Physician_____ Phone_____
Counselor/Other_____ Phone_____
Psychiatrist_____ Phone_____
Spiritual Advisor _____ Phone _____

IN CASE OF EMERGENCY PLEASE CONTACT; (Print)

_____	_____	_____	_____
Name	Relationship to You	Home Phone	Cell Phone

It is important to disclose all nutritional, herbal, vitamin, and mineral supplements, and conventional or non-conventional medications and therapies. Failure to do so may adversely affect your therapy, coaching, nutritional care plan and optimal health and life benefits. Again, welcome to my health and life skills program! I look forward to helping you reach your goals.

Alice Baland, MA, LPC, RDN, Licensed Professional Counselor, Weight Management/Body Image Expert, Registered Dietitian Nutritionist, Eating Disorders Specialist, Nutrition Therapist, Speaker

CLIENT CONSENT TO PSYCHOTHERAPY AND/OR NUTRITION THERAPY:

- I have read and understand the information about services and policies and asked any questions.
- I understand that I may have a copy for future reference if requested.
- I agree to be responsible for all charges for myself/spouse/child/children at the time of service.
- I agree to therapy with Alice Baland and know that I can stop at any time with 48 hours advance notice.

_____ _____
Signature (self or parent of child under 18) Date/Year

_____
Client Name (PRINT)

Client Assessment Form – Page 1

Alice Baland, MA, LPC, RDN – 214-335-5556. 1st Appt: _____

Identification **E-mail**_____ **Appt. Date:**_____

Name_____

Address_____City/State_____ Zip_____

Cell Phone: ( ) _____ Home Phone ( )_____
Work Phone ( )_____ Best Time to Reach You: _____

Date of Birth_____ Age_____ Gender_____ Race_____

Marital Status_____ Drivers License # & State_____

Employer/Company Name_____Occupation_____

Spouse, Parent or Child Name_____ Best Phone ( )_____

Primary Care Physician (or Referring Doctor or Professional)

Name_____ Phone ( )_____

Address_____ City_____ Zip_____

Date of Most Recent Exam and/or Lab Work: _____ Diagnosis _____

Major Medical Conditions:
___ Reactive Hypoglycemia ___ Menopausal ____ Post/Pre Menopausal ___ Diabetes I/II
___ Binge Eating Disorder ___ Bulimia ___ Anorexia ___ Restrictive Eating __ Anxiety
___ Depression ___ GERD/Acid Reflux ___ High Cholesterol/Triglycerides ___ Arthritis
___ Bipolar ___ ADD/ADHD ___ DID ___ OCD Other _____
___ Pre- or Post-Bariatric Surgery (type & surgeon: _____
___ Other, Please name: _____

Any prior surgeries? Dates, reasons, type of treatment: _____
_____

Any other health care provider you see (psychiatrist, psychologist, therapist, chiropractor, physical therapist, dietitian, personal trainer, massage therapist, herbalist)

How Did You Hear About Me? Circle: Doctor Therapist Friend Alice's Website Dietitian Internet Listing Eating Disorder Referral Network Other Thank you!

Name_____ Phone ( )_____

Client Assessment Form – Page 2. Alice Baland, MA, LPC, RDN

Effective treatment begins after an accurate assessment has been made. This form is crucial in developing an appropriate treatment plan. Please answer the following questions as completely as possible:

What is your chief concern at this time? _____

_____

_____

What current **stresses** are you faced with? _____

_____

Medical/ Diet History: BMI _____ **% IBW** _____ **Weight/Size Goal:** _____

Height_____ Current Body Weight _____ How Long? _____ Highest Weight_____

Lowest Weight_____ Most Weight Lost: _____. Regained? ____ Gained More? _____

Diets Tried: Wt. Watchers. Atkins. South Beach Weight Watchers Diet Pills Others:

_____

Age at First Diet: _____. Overweight as a Child? _____ Parents Overweight? _____

How Long Dieting? _____ years. Are you currently exercising? _____ What?_____

How often? _____ How many minutes per day/week? _____

What current problems are preventing you from eating as you would like? _____

_____

Are you (circle) currently, or have a history of, food bingeing?___ Circle and describe any use of: laxatives, diuretics, diet pills, purging, or food restriction? Number & how often?

_____

_____

Women: Have you ever experienced the absence of three or more periods other than during pregnancy? Yes_____ No_____ When? _____

Habits/Caffeine, etc. :

It is important to give honest estimates of your intake of the following: (Current)

Nicotine: Packs per day_____ Years of smoking_____(past or now?)

Caffeine: Daily Intake of Coffee _____ cups; Tea _____cups. Herbal Tea _____

Cola Drinks _____; Caffeine Pills_____

Alcohol: Highest intake in 24 hour day – Current_____ Past_____

Average daily consumption_____ Average weekly consumption_____

Include Wine _____/day; Beer _____/day; list others _____

Comments:_____

_____

Other: Marijuana, cocaine, amphetamines, LSD, heroin (or other IV drugs), mushrooms, ecstasy, inhalants, prescription narcotics or other substances. Please circle and describe: (Present or past): _____

_____

Current Prescription and Over-the-Counter **Medicines,** Vitamin/Mineral **Supplements:**

Please give name, dosage, and duration: _____

_____

Comments: _____

List any **allergic** reactions you have had to any medication, food, or other substances:

_____

_____

Client Assessment Form – Page 3. Alice Baland, MA, LPC, RDN

HPI: Please describe in detail the **stress, depression or anxiety** symptoms you have experienced:_____

_____

When would you estimate these symptoms began?_____

_____

What has been the course of your symptoms? (i.e. getting better, worse or staying the same; also, give the time frame)_____

_____

Have you experienced similar symptoms before? (Please describe and give time frame) __

_____

_____

What have you tried that has made the symptoms better? _____

_____

_____

What have you tried that has made the symptoms worse? _____

_____

_____

Please describe any "Yes" answer to the questions below:

Consistently down or depressed mood most of the day, nearly every day? ___ Yes ___ No

_____

Diminished level of interest or pleasure in most or all activities? ___Yes ___No _____

_____

Change in appetite? ___ Yes ___ No _____

_____

Change in weight? ___ Yes ___ No _____

Change in sleep pattern? ___ Yes ___ No _____

Feeling agitated or slowed down? ___ Yes ___ No _____

_____

Fatigue or loss of energy? ___ Yes ___ No _____

Feelings of worthlessness or excessive guilt? ___ Yes ___ No _____

_____

Difficulty thinking or concentrating? ___ Yes ___ No _____

_____

Client Assessment Form – Page 4. Alice Baland, MA, LPC, RDN

Decrease in sex drive or desire? ___ Yes ___ No. Increase in sex drive or desire? _____

Irritability, rage, or violent behavior? ___ Yes ___ No. How long? _____
What triggers it? _____

Attacks of hyperventilation, palpitations or intense fear? ___ Yes ___ No _____
_____

Increase in drinking and/or drug use? ___ Yes ___ No. When? _____
What?_____ **Thoughts of death or suicide?** ___ Yes ___ No.
Any suicide attempts? ___ Yes ___ No. When?_____
How? _____

Do you have access to any firearm (handgun, rifle, shotgun, etc.)? ___ Yes ___ No _____
Where? _____

Psychiatric Medical History:
Any prior psychiatric evaluation? Please name the psychiatrist, dates of treatment, diagnosis, and treatment response: _____
_____
_____
_____

Any prior psychiatric hospitalization? Give name of hospital, psychiatrist, dates, treatment and response: _____
_____
_____
_____

Have you ever been, or are you now, in therapy? Give name of therapist, dates, and describe the issues that were addressed: _____
_____
_____
_____

Please list all the psychiatric **medication** (for depression, anxiety, insomnia, etc.) you are currently taking. Describe any benefits or side effects that you experienced. _____
_____
_____
_____

Who is part of your **safe,** support network, friends, family? _____
_____
_____

Any phobias or unusual fears? ___ Yes ___ No What? _____
_____

Ever experience auditory or visual hallucinations? ___ Yes ___ No _____
_____

Ever experience a "natural high" in absence of substance abuse (with increase energy, mood, talkativeness, decreased need for sleep, etc.)? _____
_____

For Women Only: Ever notice any change in mood or behavior *after giving birth or pre-menstrally*? Please give details (since when? how often?): _____
_____

Past Medical History:
Please describe in detail if you have experienced any of the following (age, frequency, etc:

Intrusive thoughts of traumatic events _____
_____

Recurrent nightmares _____
_____

Flashbacks of frightening events _____
_____

Prolonged loss of time _____
_____

Avoidance of specific situations _____
_____

Chemical Dependency:
Ever miss work or school due to being hung over, ever had any blackouts, accidents, legal (DWI, PI), health, marital or other problems? Please circle and describe _____
_____
_____

SAD: Ever notice any seasonal change to your mood or energy (i.e. fall/winter/ vs. spring/ summer)? _____
_____

FMS: Are you familiar with the concept false memory syndrome (that "repressed memories" may be inaccurately remembered)? _____
_____

_____

Client Assessment Form – Page 6. Alice Baland, MA, LPC, RDN

At what age, and of what, is your first memory? _____
_____

At what age do you begin to remember events consistently? _____

Do you have any significant gaps in your memory? _____
_____

STAR: Please describe any **physical, emotional, and/or sexual trauma or abuse** you have experienced; your age(s); who? what? when? _____
_____
_____

If you have a trauma history, how much of the details have you processed in treatment?
_____
_____

To whom have you disclosed these experiences? What was their response? _____
_____

OCD: Ever experience persistent obsessive thoughts or images of contamination, aggressive, sexual, or religious fantasy or pathological doubt? _____
_____
_____

Ever experience persistent compulsive behaviors, cleaning/washing, checking, counting, tapping, touching, repeating, or arranging/ordering? _____
_____

OSA: Have you ever been informed that you snore loudly or that you stop breathing while sleeping or wake up gasping for breath? _____
_____

DREAMS: Have you ever had recurrent dreams or nightmares? ___ Yes ___ No
When? _____
Do you keep a dream journal? ___ Yes ___ No _____

PMH: Medical/Surgical
Any prior injuries, falls or accidents (especially any that resulted in a loss of consciousness)? _____

Have you ever had a seizure or seizure disorder? _____
_____

Have you ever had a MRI or CAT Scan of the head? Give dates and findings _____
_____

Client Assessment Form – Page 7. Alice Baland, MA, LPC, RDN

Family History:
Research has shown that heredity is important in many psychiatric disorders. Please take the time to think of your various blood-related kin. Indicate any who have had similar symptoms as yourself. Also, note if any had problems (even if no treatment was received) with the following: *anxiety, depression, manic depression, post-partum depression, changes in behavior or mood, eating disorders, phobias, suicidal behavior, drug or alcohol dependency, schizophrenia or Alzheimer's disease.* Please note any other psychiatric or known medical problems.

RELATIVE **PROBLEM** **LIVING?** **AGE @ DEATH**

Please describe in detail a *typical* **24 hour food/beverage intake, with amounts, times:** (This is helpful for all clients). Start with first food intake, time, amount, etc.
Time **Food/Beverage** **Amount** **Prep** [Use ONE LINE per food]

During the Night Foods and Beverages: _____

Social History:
Home Town_____ Length of time in local area_____
Level of Education_____ Major_____
School_____ Graduation Date_____
Occupation_____ Length of Employment_____

Sleep Pattern: # hours per night ____ How long? _____ mos./yrs. Hard to get to sleep? ___ Wake up during night?___ How often? ___ Take meds to sleep? ___ What? ____
Describe what you eat or drink 4 hours *prior* to scheduled sleep time:_____

Nutrition/Eating/Activity History:
Do you eat breakfast, lunch, breaks, and/or dinner at work/activity/therapy? Circle.
Do you take food with you to work, elsewhere?_____
Describe some examples: _____
What do you typically eat for breakfast?_____
Lunch?_____
Dinner?_____
Who prepares the meals at home?_____
How many meals do you eat out during the week? _____
How many meals and snacks do you eat during a 24-hour period? _____
Name your favorite foods, ethnic foods, and snacks: _____
_____
What are your three favorite restaurants? _____
What percentage of the time do you travel? _____
What is the most difficult time of day for stress eating? _____
What is your rate of eating? Slow _____ Moderate _____ Fast _____ Inhale _____
Circle if you experience these symptoms: Gas Bloating Constipation Diarrhea Heartburn List any others: _____

Describe a typical "*good day*" of eating: _____
_____
_____
_____

Describe a typical "*bad day*" of eating: _____
_____
_____
_____

(continue on separate page, if needed)

What kind of support do you receive from your spouse/family/SO for your weight, eating, nutrition, or diet goals? _____
_____

What kind of physical activities, sports, etc. do you engage in, how long per session, and how often during a typical week?_____
_____
_____

How do you **feel** about participating in exercise, sports, dance, walking, etc.? (Love, hate, too busy, embarrassed, indifferent, etc.). Please circle and describe._____

_____

At what age did *"play"* become "*exercise/work*?" _____

Body Image

On a scale of 0 to 10, with 10 being the highest, please circle how you currently feel about your body (size, shape, weight, etc.): 0 1 2 3 4 5 6 7 8 9 10

What would you most like to change about your body? _____

What do you like best about your body?_____

What messages did you receive as a child about your body? _____

_____

About eating patterns/body size/being fat/skinny, other? _____

_____

Diet History

At what age was your first diet? _____ How did you do? _____

How many diets have you been on in the past 3 years? _____

What is your current food/meal plan? _____

What is the MOST weight have you lost? _____ Gained? _____

Who in your family is overweight? Father?_____ Mother?_____

Paternal Grandfather? _____Paternal Grandmother? _____

Maternal Grandfather? _____ Maternal Grandmother? _____

Brothers/Ages?_____ Sisters/Ages?_____

Name Children (Current Ages and If Overweight): _____

_____

Family History of Diabetes (List who):_____

Impaired Glucose Tolerance _____ Hypoglycemia _____ Hypertension _____

Heart Disease, High Cholesterol/Triglycerides _____

Health

Please circle how you feel about your **current health (physical and emotional)**:

Excellent Very Good Good Fair Poor Very Bad

What do you believe is of **greatest importance** in improving your **health** and/or **life?**

_____

_____

_____

What **expectations or goals** do you have for our first few sessions?

_____

_____

_____

What **obstacles** do you anticipate? _____

Please list any concerns or hopes you have that were not mentioned earlier.

(Thank you for completing these forms! Please bring them to your first session!)

Alice's Notes:

Next Appointment Day/Date/Time: _____

Initial Care Plan: _____

Homework:_____

SAFETY CONTRACT

(This is to assure your safety. I request that all clients read and sign it please).

Client Name: (PRINT)_____

By signing below, I agree to the following:

1. **To make a binding commitment to LIFE.**

   I permanently reject suicide as an option, although I understand that I may continue to experience suicidal thoughts of impulses (if I have them).

2. **To call my treatment team (psychiatrist) and follow their directions, if I experience any loss of impulse control or wish for self-harm; and/or call 911 and/or go to the nearest Emergency Room for treatment.**

_____ _____

Client Signature Date

_____ _____

Witness/ *or* Alice Baland Date

Alice Baland's LIFE SOLUTIONS CENTER, LLC
5172 Village Creek Drive, Suite 101, Plano, Texas 75093
214-335-5556

HIPAA PRIVACY FORM
Alice Baland, MA, LPC, RDN
Consent for Use and Disclosure of Health Information

SECTION A: CLIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Social Security Number: _____ Patient #, if any: _____

SECTION B: TO THE CLIENT – Please read the following statements carefully.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we do change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Thos changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Alice Baland, MA, LPC, RDN
Telephone: 214-335-5556
Email: info@EatUpTheGoodLife.com
Address: 5172 Village Creek Drive, Suite 101, Plano, Texas 75093

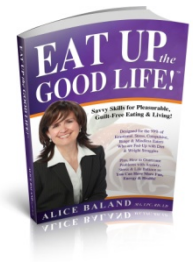
Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person named above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, (PRINT:_____, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out any treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the client, complete the following:
Personal Representative's Name: _____
Relationship to Client: _____

You are entitled to a copy of this consent after you sign it if you wish.

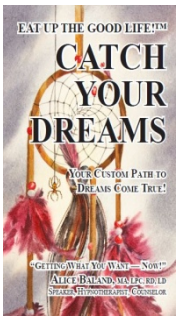


Books by Alice Baland: EAT ***UP THE GOOD LIFE!*** *is the perfect antidote for our country's toxic preoccupation with weight and diet prescriptions. It includes fresh, simple solutions for overcoming overeating and overweight, stress and anxiety so you or your loved ones can have more fun, energy, health and a better balanced life!*
Randy Rolfe, Family Therapist, Author of *You Can Postpone Anything but Love.*

Designed for the 99% of Emotional, Stress, Compulsive, Binge and Mindless Eaters who are fed-up with diet and weight struggles, Alice shows readers how to stop using food, weight and eating as a distraction to living The Good Life – and how to fill the emotional void with a lavish buffet of delicacies for Body, Mind, and Spirit. Feed your Earth Suit the best fuel combinations to balance out your favorite fun foods – without guilt or deprivation! Find out how in this book.

Discover what's in the Nutrition Kit, how to satisfy the Two Hungers, how to care for your Earth Suit, be accountable, the two essentials to Curb Cravings, over 65 Savvy Skills and the ABC's of How to Eat Up The Good Life!

This rich resource and guidebook is perfect for all eaters, educators, clinicians, parents, students, normal eaters and YOU! This is the Right Way and the Right Time to transform your relationship with food, eating and yourself. ***EAT UP THE GOOD LIFE!*** puts a positive spin on eating, rather than vilifying food. How refreshing! **$24.97** (plus 3 free gifts!) Get yours now at www.EatUpTheGoodLife.com (and 3 free gifts valued at $65.00!)



CATCH YOUR DREAMS! by Alice Baland, is the perfect playbook and action guide to inspire and help you achieve your dreams and highest potential. Three easy steps show you how to make this happen:

1.) Release your potential; 2.) Refine your vision; 3.) Reap the rewards!
So that your Mind, Spirit and Body Convey Confidence, Vibrate with Energy, Gag the Guilt, Balance Your Best, Shine with Success!

You'll brainstorm with the 100 Dreams activity. Later you will narrow your choices to seven categories to balance your life. You'll visualize and refine these and choose your special one dream on which to focus.

All categories have plenty of space to write, journal, draw, create a collage, cut and paste visuals. Beautiful photographs in each section and fabulous quotes set the stage for releasing and implementing your dreams. Become and achieve what you most want in life!

CATCH YOUR DREAMS is not only beautiful, it's your personal Dream Book. You'll love it and use it daily. It is spiral-bound for ease in laying flat and really losing yourself in your vision of the future. Margins on every page coordinate a beautiful photo from the section header to keep you on target and motivated.

Best of all, this is the place where you create Your Custom Path to Dreams Come True – Getting What You Want…Now!
CATCH YOUR DREAMS makes an ideal gift for yourself, professionals, students, parents, dreamers, and anyone who yearns for more in life! **$24.97 .Bonus: Receive 3 Free Gifts valued at $65 when you sign up on the Home Page: www.EatUpTheGoodLife.com**

SERVICES: Speaking for your group; counseling for depression, anxiety, eating disorders, weight management, prevention, Medical Nutrition Therapy (as diabetes, reactive hypoglycemia), individual and family nutrition; nationwide phone coaching, personal and career development, couples, marriage and family, trauma, grief. Alice offers supermarket nutrition tours for gluten-free, allergies, sports nutrition, families, individuals and special diets. Ask about special programs and packages.

Pre-Authorized Consultation/Payment Agreement

Alice Baland has my permission to charge consultation fees to my:

_____ **VISA** _____ **MasterCard**

Note: Payment for in-person sessions, phone sessions, any sessions missed without 24-hr. **phone** cancellation will be charged. (full fee stated in Informed Consent signed by client; insurance does not pay for these), court appearances, consults with attorneys, physicians or others, associated fees.

Credit Card Number _____--_____--_____--_____

Expiration Date (month/year) _____/_____

Name/Initial on Card_____

Signature _____ **Date** _____

Client Name _____

Billing Address_____

City/State/Zip _____

Email _____

Please Complete, Sign, and Return
Fax: 214-291-5354 (or bring to your first session with Alice)
Alice Baland's Life Solutions Center, LLC
5172 Village Creek Drive, Suite 101, Plano, Texas 75093
EatUpTheGoodLife.com Alice@EatUpTheGoodLife.com

Alice Baland, MA, LPC, RDN
214-335-5556

This packet is for:

Psychological Evaluation for Bariatric Surgery
(such as **Lap Band, Gastric Sleeve**, etc)

Please complete the entire form to the best of your ability.

Fax It to Her for Psych Evals by Phone
214-291-5354
(Confidential Fax)

PAYMENT:
You must complete and fax the
Pre-Authorized Consultation/Payment Agreement
48 Hours BEFORE your appointment to reserve your time

Thank you!

[There is a SEPARATE 3 PAGE FORM for
NUTRITION ASSESSMENT
to complete prior to surgery]

ATTENTION: Please cancel or change appointments AT LEAST 24 Hours Before an Appointment and no later than 9 AM Friday for a Monday Appointment.
Call **214-335-5556** and leave a message 24/7

EAT UP THE GOOD LIFE!

Savvy Skills for Pleasurable, Guilt-Free Eating & Living!

Alice Baland, MA, LPC, RDN. ***Your Good Life Guide!***
Psychotherapist, Dietitian, Hypnotherapist, Speaker, Author.
Overcoming Obstacles with Personalized Eating & Life Plans so you can:
EatUpTheGoodLife.com 214-335-5556. Plano, Texas and The World!

Hi! I'm Alice Baland, Psychotherapist and Dietitian. I can do your Psych Eval by phone, or your Nutrition Assessment by phone, or BOTH by phone!

How easy is that?! Just let me know your preference and I will be happy to help you out.

1. Complete all the forms.
2. Fax to me at 214-291-5354 48 hours in advance
3. Call me for an appointment at 214-335-5556
4. After your telephone appointment, I'll complete your reports and fax to your surgeon.
5. I'll mail or email your receipt and Nutrition Education forms on what to eat before and after surgery.
6. That's it. So easy!

Talk with you soon!

Warm regards,

Alice

Alice Baland
Eat Up The Good Life! ™