the TNC GROUP PLLC

PSYCHOTHERAPY | COACHING | TRAINING

MINOR CLIENT INFORMATION QUESTIONAIRRE

Your cooperation in completing this questionnaire will be helpful in planning our services for your family.

ABOUT THE MINOR

Full Name: _____ **Date:** _____

Date of Birth: _____ **Age:**_____

Birthplace:_____

Address:_____

***Guardian/Responsible Party*:**

Name of parent(s)/guardian(s) who have legal custody of child. (All legal parent(s)/guardian(s) must provide written consent for services):_____

Relationship to child: _____ **Date of Birth:** _____

Ethnicity *Optional: White Black/African-American Hispanic Asian Native American

Other: _____

Address: _____

Phone number: _____ **Alternative number(s):** _____

Please indicate if a message can be left at any of these numbers ___ Yes ___ No

Email address: _____

Other adults involved in minor's life:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

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Who referred you to us? *Please check one*:

___ **Internet** ___ **Family (name):** _____

___ **Physician (name):** _____ **Professional name:** _____

___ **Place of Worship, if applicable (name):**_____

___ **School (name):** _____ **Other:** _____

MEDICAL HISTORY

Is the minor currently under a doctor's care? __Yes ___No **If yes, for what diagnosis?** _____

Approximate date of last medical examination (month/year): _____

Is the minor presently taking any medications? ___ Yes ___ No **If yes, please list, and reason why:** _____

_____

_____

_____

Does the counselor have your permission to contact your physician in order to coordinate services? ___ Yes ___ No

Many parents have opinions on psychiatric medications, what are yours? _____

_____

_____

_____

Does your child have any allergies (food, environmental, medicinal, animal, etc.)? _____

_____

_____

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what? _____

_____

_____

DEVELOPMENTAL HISTORY

Is the minor adopted? ____Yes ____No **If yes, give the date of adoption:**_____

Date of adoptive placement(s) (for adoptees):_____

Birth country (for transnational adoptees): _____

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Tell us about your child's development milestones (delayed, on time, early): _____

_____

_____

_____

Describe any complications during pregnancy or birth: _____

_____

Any problems feeding? ____ Yes ____ No **Eating?** ____ Yes ____ No **Sleeping?** ____ Yes ____ No

If yes, describe: _____

_____

Has there been any physical or emotional separations between child and care-taking adult during first 24 months of life?

____Yes ____No **If yes, describe:**_____

_____

Are there special problem areas or history of particular stress for this child?_____

_____

_____

_____

SCHOOL INFORMATION

School:_____ **District:**_____ **Grade:**_____

Any special educational arrangements? _____

Any specific concerns of teachers about this child? _____

_____

_____

Does this child:

Get along well with teachers? ____Yes ____No

Get along well with adults? ____Yes ____No

Get along well with other students? ____Yes ____No

Have difficulty making friends? ____Yes ____No

Struggle with schoolwork? ____Yes ____No

Work at grade level or above? ____Yes ____No

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Has your child ever been held back or receive specialized academic services? If so, for what? _____

_____

_____

_____

What concerns, if any, do you have about your child's education or schooling (grades, peers, relationships with teachers, etc)?

_____

_____

What would your child say he/she likes and dislikes about school?

Likes: _____

Dislikes: _____

FAMILY & RELATIONSHIP INFORMATION

Parent's marital status: Married Divorced Never Married Separated Domestic Partners Widowed

Please list all individuals that are currently living in the home with minor:

Name(s)	**Age/Grade**	**Relationship**	**Occupation**	**Ethnicity/Race**

_____

_____

_____

_____

_____

If one or both parents are absent, please share how long and reason for absences:

_____

_____

_____

If parents are not together please describe the parents' relationship with one another:

_____

_____

_____

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Please list any health problems for which you or any other family member are currently receiving treatment (including diabetes, heart disease, cancer, etc.) _____

_____

_____

Indicate any mental health problem(s) that exist in the minor's <u>immediate or extended families.</u> Please list the relatives relationship or names next to the corresponding mental health problem.

Depression: _____ **Bipolar Disorder:** _____

Anxiety Disorder: _____ **Drug/Alcohol Addiction:** _____

Obsessive/Compulsive Disorder: _____ **Schizophrenia:** _____

Suicide: _____ **Other:** _____

Has the minor suffered loss(es) by death(s)? ___ Yes ____ No **If yes, list the loss(es) below:**

Name	**Relationship**	**Date of Death**	**Cause**

Has the minor experienced any other significant losses in the past year? If so, please list (i.e.: divorce/separation, terminal illness, pet loss, etc.**):** _____

_____

_____

List 5 or more strengths of your family:

_____

_____

_____

_____

_____

_____

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Is there anything that gets in the way of your family being the way you want it to be? _____

_____

_____

_____

SPIRITUAL HISTORY

Present Religious Affiliation, if any: _____

If currently attending religious services, how often does minor attend? _____

Is attending religious services or spirituality an important part of your/minor's life? ___Yes ___No

Who else do you consider to be part of, or supportive to your family (people or affiliations):

_____

_____

_____

EMOTIONAL HISTORY

Is the minor currently experiencing strong emotions? ___Yes ___No **If Yes, please describe:** _____

_____

Does the minor often make decisions based on emotions? ___Yes ___No

Has the minor ever had <u>any thoughts</u> of suicide or harming or cutting yourself in anyway? ___Yes ___No

If Yes, when (year and how many times this has occurred) _____

_____

Has the minor <u>actually attempted</u> suicide or harmed themselves by any method? ___Yes ___No

If Yes, what did you do, and what year did it occur? _____

_____

Has the minor ever felt like he/she wanted to seriously hurt or harm someone else? If yes, please explain:

_____

_____

_____

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Is there any history past or present of abuse or violence? ___Yes ___No **If so, please explain:** _____

_____

_____

_____

Is the minor currently using any illegal drugs or is the reason you are seeking therapy services substance related?

_____

_____

_____

Does your child have reoccurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? If so, please explain: _____

_____

_____

_____

A**re you concerned your child may see or hear things that don't appear to be real? If so, please explain:** _____

_____

_____

_____

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put him/her at risk? If so, please explain? _____

_____

_____

_____

Do you have any concerns about your child's sexuality, gender or sexual development?_____

_____

_____

_____

Has your child ever been physically, sexually, or emotionally abused? If yes, at what age? Please indicate the abuser (parent, friend, teacher, etc.) **and the type of abuse?**_____

_____

_____

_____

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Has your child ever witnessed or experienced any childhood trauma(s) that has strongly impacted their life (divorce of a parent, loss of a close relative, witness to violent crime, abandonment by a parent, etc.)**? If yes, please describe:**

_____

_____

_____

_____

_____

_____

Circle any of the following which are presently causing the minor difficulty:

Abuse
Confusion
Nightmares
Alcohol use
Dating
Health Problems
Allergies
Decision making
Inferiority
Parents
Stress
Ambition
Depression
Suicidal ideation
Anxiety
Relaxation
Temper
Drug use
Religion
Tiredness
Assertiveness
Education
Legal matters
Sadness
Ulcers
Asthma
Energy
Loneliness
School
Unhappiness
Bed-wetting
Self-Concept

Memory
Self-Control
Nervousness
Separation
Friends
Concentration
Guilt
Picks at self (hair, fingers, nails, clothing)
Talks back to adults
Problems making or keeping friends
Excitable, impulsive
Wants to run things
Sucks or chews (thumb, clothing, hair, etc.)
Cries easily or often
Carries a chip on his/her shoulder
Daydreams
Difficulty learning
Restless or squirmy
Fearful
Restless or always on the go
Destructive
Tells lies or stories that aren't true
Shy
Gets into trouble often
Quarrelsome
Denies mistakes or blames others
Pouts or sulks
Steals
Disobedient or obeys resentfully
Worries a lot
Fails to finish things

Feelings hurt easily
Bullies others
Unable to stop a repetitive activity
Mean or cruel (to toys, animals, friends)
Childish or immature
Distractible or inattentive
Headaches
Mood swings
Doesn't like or follow rules or restrictions
Fights with siblings or other kids
Easily frustrated in efforts
Disturbs other children
Basically unhappy
Eating problems
Sleeping problems
Stomach aches
Other aches and pains
Boasts or brags
Feels cheated in family circle
Lets self be pushed around
Bowel problems
Clumsy
Well-Coordinated
Affectionate
Stubborn

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THERAPY HISTORY, EXPECTATIONS & GOALS

Have you ever consulted a professional counselor/therapist? ___Yes ___No

If yes, Name or agency: _____

What were the reasons for therapy at that time? _____

_____

How was counseling helpful then? _____

_____

What was NOT helpful then? _____

_____

Why have you decided to come for counseling/therapy at <u>this time</u>? What happened to make you say "A-Ha, now is the time"?

_____

_____

_____

_____

_____

_____

How long has this issue been a problem for you? _____

Please tell me anything else that you think would be helpful for me to know about your child. _____

_____

_____

_____

_____

_____

_____

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the TNC GROUP PLLC
PSYCHOTHERAPY | COACHING | TRAINING

CONSENT TO TREATMENT

The TNC Psychotherapy Group provides therapy and assessments which utilize systems, methods, and processes which include interpersonal, cognitive, cognitive-behavioral, developmental, psychodynamic, affective, family systems, and/or play therapy methods and strategies with individuals, couples and/or their families to achieve mental, emotional, physical, moral, educational, spiritual adjustment and/or career development through the changing individual and family life cycle. These approaches assist in stabilizing and alleviating mental, emotional or behavioral problems/issues of an individual, couple, or family. When an individual, couple or family makes changes, there is the possibility of discomfort or discord. If this occurs, the client(s) are asked to discuss this with the therapist. It is the hope of The TNC Psychotherapy Group to strengthen individuals and their families through counsel.

I have read and understand the treatment as described above. I authorize The TNC Psychotherapy Group to provide for my care. I also understand that I may withdraw this consent and terminate treatment at any time.

_____ _____
Client Witness

_____ _____
Client Therapist

_____ _____
Client Date

***If you are bringing a minor to therapy, please complete the following*:**

CONSENT TO TREAT YOUR CHILD:

I/we the parent(s) of: _____ give my/our consent for my/our child to be seen by: _____ for counseling. I/we acknowledge, have read and understand, that the treatment as described in the first paragraph above also applies to my/our child. I/we authorize The TNC Psychotherapy Group to provide for my/our child's treatment. I/we also understand that I/we may withdraw this consent and terminate treatment at any time.

_____ _____
Parent/Legal Guardian Witness

_____ _____
Parent/Legal Guardian Therapist

_____ _____
Date

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the TNC GROUP PLLC
PSYCHOTHERAPY | COACHING | TRAINING

HIPPA DISCLOSURE

CLIENT CONSENT FOR USE AND/OR DISCLOSURE OF HIPAA DEFINED PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out its health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that may be used by the Provider:

___ Yes ___ No — a letter mailed to me at the address provided by me

___ Yes ___ No — telephoning my home and leaving a message on my answering machine or with the individual answering the phone

___ Yes ___ No — telephoning my office and leaving a message on my phone mail or with the individual answering the phone

___ Yes ___No — an email may be sent to an email address provided by me

___ Yes ___No — a text may be sent to a number provided by me

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

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I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____
Name of Client (Printed)	Signature of Client/Parent/Guardian
_____	_____
Signature of Legal Representative (e.g., Attorney-In-Fact)	Relationship to Client
_____	_____
Date	Therapist

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

This Provider is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Provider. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT

The Provider may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Provider to use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Provider will provide your PHI to those health care professionals, whether on the Provider's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you may need to know the condition for which you are being counseled by this office.

(b) Payment - In order to get paid for services provided to you, the Provider will provide your PHI, directly or through a billing service, to appropriate third party payee, pursuant to their billing and payment requirements. For example, the Provider may need to provide information to your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations - In order for the Provider to operate in accordance with applicable law and insurance requirements and in order for the Provider to continue to provide quality and efficient care, it may be necessary for the Provider to compile, use and/or disclose your PHI. For example, the Provider may use your PHI in order to evaluate the performance of the Provider's personnel in providing care to you.

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NO CONSENT REQUIRED

The Provider may use and/or disclose your PHI, without a written Consent from you, in the following instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Provider obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Provider in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payee.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations:
- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Provider attempts to obtain your Consent as soon as possible; or
- (ii) To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Provider has been unable to obtain your Consent and the Provider determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Provider is required by law to make such disclosure. For example, the Provider is required by Section 681.43 of the Texas Administrative Code to report (1) abuse or neglect of minors, (2) abuse, neglect, or exploitation of elderly or disabled persons, (3) abuse, neglect, and illegal, unprofessional, or unethical conduct in an inpatient mental health facility, a chemical dependency treatment facility, or a hospital providing comprehensive medical rehabilitation services, and (4) sexual exploitation by a mental health services provider.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - If you are involved in a lawsuit or a dispute, the Provider may disclose medical information about you in response to a subpoena, a court order, or administrative order. For example, the Provider may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, court order, warrant, summons or similar process. The Provider may disclose your PHI if the Provider believes that a death was the result of criminal conduct. The Provider may disclose your PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness, missing person, or to report a crime.

(k) Coroner or Medical Examiner - The Provider may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Provider may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Provider is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(n) Avert a Threat to Health or Safety - The Provider may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.

(p) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Provider may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

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q) National Security and Intelligence Activities - The Provider may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(r) Military and Veterans - If you are a member of the armed forces, the Provider may disclose your PHI as required by the military command authorities.

(s) Protective Services for the President and Others - The Provider may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.

APPOINTMENT REMINDER

The Provider may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Provider with your consent:

(a) telephoning your home and leaving a message on your answering machine; and/or

(b) telephoning your cell and leaving a message on your phone mail.

DIRECTORY/SIGN-IN LOG AND APPOINTMENT CALENDAR

The Provider does not maintain a sign-in log for individuals seeking care and treatment in the Provider's office. The Provider does maintain a secured appointment calendar which is located in a position where the Provider and staff can readily see the initials of who is seeking care in the office.

FAMILY/FRIENDS

The Provider may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Provider may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

If you are present at or prior to the use or disclosure of your PHI, the Provider may use or disclose your PHI if you agree, or if the Provider can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

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(a) If you are not present, the Provider will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Provider's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Provider is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Provider's Privacy Officer. In your written request, you must inform the Provider of what information you want to limit, whether you want to limit the Provider's use or disclosure, or both, and to whom you want the limits to apply. If the Provider agrees to your request, the Provider will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Provider's Privacy Officer. The Provider will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Provider's Privacy Officer. The Provider can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Provider may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Provider's Privacy Officer. You must provide a reason that supports your request. The Provider may deny your request (1) if it is not in writing, (2) if you do not provide a reason in support of your request, (3) if the information to be

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amended was not created by the Provider (unless the individual or entity that created the information is no longer available), (4) if the information is not part of your PHI maintained by the Provider, (5) if the information is not part of the information you would be permitted to inspect and copy, and/or (6) if the information is accurate and complete. If you disagree with the Provider's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Provider's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Provider may charge you for the cost of providing additional lists. The Provider will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Provider upon request to the Provider's Privacy Officer.

(h) Complain to the Provider or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Provider, you must contact the Provider's Privacy Officer. All complaints must be in writing.

PROVIDER'S REQUIREMENTS

The Provider:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Provider's legal duties and privacy practices with respect to your PHI.

(b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your mental health records than is provided for under federal law. In particular, the Provider is required to comply with the Texas Health and Safety Code, Chapter 611, concerning confidentiality and access to records.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of April 14, 2003 and updated as of October 13, 2014.

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OFFICE DIRECTIONS

Address:
Cedar Place
407 N. Cedar Ridge Dr., Suite 235
Duncanville, Texas, 75116

Parking: Parking is free. You may park in front of the building upon arrival. We encourage you to give yourself extra time before your first visit so you will have ample time to park and find your way to our office.

Entry: Doors to the building are open between 9am and 6pm. Once in the building, you will take the main lobby elevators to suite 235 on the 2nd floor. If you are coming after hours or on the weekend, you will need to call your therapist and they will come downstairs to open the door for you.

Directions: If you are traveling South from Dallas, merge onto I-35E S/US-77 S toward Waco. Merge onto US-67 S toward Cleburne. Merge onto I-20 W toward Ft Worth. Take EXIT 461 toward Cedar Ridge Dr.
Turn left onto Escuela Dr. Turn left onto N. Cedar Ridge Dr. Make a right into the parking lot of the Cedar Place building. If you are traveling East from the Arlington/Ft. Worth area, merge onto I-20 E. Take EXIT 461 toward Cedar Ridge Dr. Turn right onto N. Cedar Ridge Dr. Make a right into the parking lot of the Cedar Place building.

Address:
Meadow Park Tower
10440 N. Central Expressway, Suite 800
Dallas, Texas, 75231

Parking: Parking is free. You can park in front of the building (facing the access road), on the ground level of the parking garage, or behind the parking garage. Please give yourself extra time before your first visit so you will have ample time to park and navigate the building.

Entry: Doors to the building are open between 8am and 5pm. Upon arrival, you will take the main lobby elevators up to the 8th floor and enter the reception area. The receptionist will buzz our office and your therapist will come get you from the waiting area. If you are coming after hours or on the weekend, you will need to call your therapist and they will come downstairs to open the door for you. There is also an after-hours security guard, and they are often willing to let you in if we give them a heads up that you are coming.

Directions: If you are traveling North from the downtown area on 1-75, take the Walnut Hill/Meadow exit. The first tall office building after Meadow, on your right, is the building in which our offices are located. If you are coming South from I-75/I-635, exit Walnut Hill/Meadow, and make a u-turn at Meadow. The building has two signs on it – Walters, Balido & Crain/Eberstein-Wither. Make an immediate right into the building parking lot.