



NEW CLIENT INFORMATION

Date: ___/___/___

Client Name: _____ Date of Birth: ___/___/___

Sex: Female Male Marital Status: Single Married Other Employed: Yes No

If minor, name of Parent(s)/Guardian(s): _____

Parent Cell Phone(s): _____

Current School attending: _____ Grade: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we contact you and leave messages at these phone numbers? Yes No

Home Address: _____
(Street) (City) (State) (Zip Code)

May we mail information to this address: Yes No

If "no" please give mailing address: _____

Email: _____ May we email information to you? Yes No

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Date of Birth: ___/___/___

Sex: Female Male Marital Status: Single Married Other

Employer: _____ Occupation: _____

Home Address (if different): _____
(Street) (City) (State) (Zip Code)

Contact Number (if different): _____ Social Security #: ___/___/___

ADDITIONAL CLIENT INFORMATION

How were you referred to our office? Internet Insurance Provider Doctor Current/Past Client

Who may we thank for referring you? _____

Primary reason for visit: _____

Previous Therapy/Counseling: Yes No If "yes"; with whom: _____

Family Physician: _____ Date of client's last Physical: _____

Overall Health: _____ Any chronic health conditions?: _____

Current Medications: _____

List names/age of immediate family members or others living in the home: _____

CONFIDENTIALITY STATEMENT:

All information shared in this treatment is confidential except in circumstances governed by law. If you would like us to confer with another healthcare professional, school, attorney or any one else pertaining to the client, you will need to sign a "Release of Information" form. Both parties agree to take all reasonable measure to ensure confidentiality with any communication over the telephone and/or Internet.

FINANCIAL AGREEMENT:

Any additional professional services rendered at your request, such as phone contact over 5 minutes, consultations with other professionals, preparation of special forms, reports, letters, etc. will be billed at the rate of \$130.00 per hour. Emergency after-hours appointments will be billed at a rate of \$200.00 per hour. If we are involved in any legal endeavors on your behalf and/or are subpoenaed, there will be an upfront payment of \$200.00 per hour. INITIAL _____

NO-SHOW/LATE CANCELLATION POLICY:

Your visit has been reserved for you. 48-business-hours' notice is required to give us ample time to fill your appointment. If you do not cancel prior to 48 business hours in advance, there will be a no show/late cancel fee of \$130.00 per hour. For group therapy sessions or social skills classes, the no show/late cancel fee is \$65.00 per hour. Please note that reminders are sent by our administrative staff to assist you in remembering your appointment, but are done as a courtesy and should not be relied upon. Absence of a reminder from our office does not relieve you of your responsibility to adhere to the cancellation policy. INITIAL _____

PAST DUE BALANCE:

The undersigned understands and agrees to accept full financial responsibility for all charges. The clinician reserves the right to collect payment from the client and/or client's guarantor. Should the account be referred to an attorney or collection agency, the undersigned will be responsible for actual attorney fees and/or collection expenses.

CREDIT CARD INFORMATION: Credit Card type: Visa MasterCard Discover

I authorize **Stone Creek Psychotherapy** to keep my signature on file and to charge my account for recurring charges, on-going treatment and account balances. I understand that this form is valid for 4 years unless I cancel through written notice to the health care provider.

Client's Name: _____ Card Holder's Name: _____

Credit Card #: _____ Exp. Date: ____/____ 3-digit CVD code: _____

Signature: _____

Payment is due before each session. Fees are subject to change

At Stone Creek, all of our clinicians are qualified and experienced. Some of our clinicians continue to receive supervision as a part of their licensing requirements. Interns hold a temporary license from the Texas State Board of Examiners of Professional Counselors, or Texas State Board of Examiners of Social Work and in order to gain full licensure, LPC-Interns and LMSWs attend weekly supervision with a board-certified supervisor for the purpose of continued training. During these supervisory experiences, cases may be discussed. Your confidentiality will be protected in supervision under the same guidelines regarding confidentiality in individual therapy. The following is a current list of our interns: Stella Lessert LMSW and Leticia White, LMSW

NOTICE OF PRIVACY PRACTICE

The notice in our waiting area describes how psychological and health information about you may be used and disclosed and how you can get access to this information.

I have read and received (if requested) and understand the privacy practices information. I understand that my signature on this form acknowledges receipt of these documents and acceptance of the conditions of the privacy policies of Stone Creek Psychotherapy & Wellness Center.

STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent.

_____	Date	_____
Client		
_____	Date	_____
Clinician		
_____	Date	_____
Parent or Guardian if minor		

Regarding release of mental health medical records for adults and minors:

Texas Health and Safety Code, Chapter 611, Mental Health records, specifically Sections: 611.0045 (c) If the professional denies access to any portion of a record, the professional shall give the patient a signed and dated written statement that having access to the records **would be harmful to the patient's physical, mental, or emotional health** and shall include a copy of the written statement in the patient's records.

INITIALS _____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize _____,
Client/Parent/Guardian Therapist's Name
(if minor) regarding, _____.
Minor Client

Mark the one(s) that apply to you:

- To disclose and discuss financial and scheduling information to anyone who is or may be responsible for payment of all or a portion of the charge. INITIAL _____

- To disclose and discuss clinical and treatment information with _____.
Other Mental Health Provider's Name OR Attorney/Law Firm

- To exchange clinical information, such as diagnosis, treatment goals, and medication issues with my Physician, _____, for the purpose of treatment planning and coordination.
Contact phone number and address: _____

- To disclose and discuss clinical and treatment information with, _____ and/or _____.
School Name Counselor /Teacher

- To disclose and discuss clinical and treatment information with, _____ please explain: _____
Other

- I prefer that no clinical and/or medical information be released at this time.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall remain in effect unless revoked or replaced. Specification of the date, event or condition upon which consent expires: _____

Client Name (Please print)

Witness

Client or Guardian's Signature

Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) 48 hours before your scheduled appointments.

Client name: _____

Your name: _____

Your email address: _____

Your home phone number: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check one)

Via a text message on my cell phone (normal text message rates will apply)

Via an email message to the address listed above

Via an automated telephone message to my home phone

None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature

Date