NEW CLIENT INFORMATION – Adult Assessment

Date:_____

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

Home Phone: _____Work Phone: _____Cell Phone:_____

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

Home Address: _____ City: _____ State: ____ Zip:_____

May we mail information to this address? ○ Yes ○ No

If "no" please give mailing address: _____

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

Sex: Female ○ Male ○ Marital Status: Single ○ Married ○ Other

Employer_____ Position _____

Previous Employers_____

Level of Education completed and name of school_____

Who may we thank for referring you? _____Reason for referral: _____

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

Family Physician: _____ Date of last Physical (client):_____

Overall Health: _____ Chronic Health Conditions: _____

Current Medications: _____

List names/ages of immediate family members: _____

List names/ages of 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:

The fee for the assessment is $_____, your initial payment is $_____ and the final payment is $_____. Additional professional services rendered at your request, such as phone contact over 5 minutes, consults with other professionals, preparation of special forms, reports, letters, etc. will be billed at the rate of $130.00 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 there will be a no show/late cancellation fee of $130.00 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 ○ Visa ○ MasterCard

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.

Patients Name: _____
Card Holders Name: _____ Credit Card #: _____
Exp. Date _____/_____ 3 digit CVD code _____

Signature: _____

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

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize _____,
Client/Parent/Guardian Therapist's Name

(if a minor) regarding, _____.

Mark the one(s) that apply to you:

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

○ To exchange clinical information, such as diagnosis, treatment goals, and medication issues with my Physician, _____, for the
Physician's Name
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 until 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 with 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.

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.

_____ _____

Client Date

_____ _____

Clinician Date

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.

INITIAL _____