



**NEW CLIENT INFORMATION – Minor Assessment**

**Date:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Parent(s)/Legal Guardian:** \_\_\_\_\_

**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 **Sex:** Female  Male

**If “no” please give mailing address:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **May we email information to you?**  Yes  No

**Current School:** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Name of Teacher(s)** \_\_\_\_\_

**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:** \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Address (if different):** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Social Security #:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Contact No. (if different)** \_\_\_\_\_

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

**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 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 cancel 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**

**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

\_\_\_\_\_  
Parent or Guardian if minor

\_\_\_\_\_  
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.

**INITIALS** \_\_\_\_\_

**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 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 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.