Stone Creek
PSYCHOTHERAPY
& WELLNESS CENTER

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: ____
(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

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

Employer: ____ Position: ____________________________

Previous Employers:____

Level of education completed and name of school:____

Who may we thank for referring you? ____

Primary concern: ____

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 INFORMATION

Family

Relationship	*Name*	*Age*	*Current Occupation/Employer*	*Highest level of education completed*
Mother				
Father				
Spouse/Partner				
Child/Sibling				
Child/Sibling				
Child/Sibling				
Child/Sibling				
Child/Sibling				

Who currently resides in the household with you? ____

____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition			Family member
Alcohol/Substance Abuse	◯ yes	◯ no	____________________
Anxiety	◯ yes	◯ no	____________________
AD/HD	◯ yes	◯ no	____________________
Depression	◯ yes	◯ no	____________________
Domestic Violence	◯ yes	◯ no	____________________
Eating Disorders	◯ yes	◯ no	____________________
Obesity	◯ yes	◯ no	____________________
Obsessive Compulsive Disorder	◯ yes	◯ no	____________________
Schizophrenia	◯ yes	◯ no	____________________
Suicide Attempts	◯ yes	◯ no	____________________

Education

Please list **where** you went to school and **describe your experiences**. Please include specific institution **names, locations and dates/ages** when known. ***BE AS THOROUGH AS POSSIBLE.***

ELEMENTARY SCHOOL: ____

____

____

____

____

JUNIOR HIGH SCHOOL: ____

____

____

____

____

HIGH SCHOOL: ____

____

____

____

____

COLLEGE:____

____

____

____

Health

Have you previously received or are you currently receiving any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

If yes, please list name(s) of past/current therapist/practitioner:____

____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list:____

____

Are you currently taking any over-the-counter medication (vitamins, allergy medication, etc.)? ☐ Yes ☐ No

If yes, please list:____

____

How would you rate your current physical health? (please select one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Please list any specific health problems you are currently experiencing:___________________________________

____

Who is your physician? ________________________________ Date of last physical exam:____________________

Do you have any past medical problems? ☐ Yes ☐ No

If yes, please describe: ____

____

____

Have you had any injuries such as broken bones or head injuries? ☐ Yes ☐ No

If yes, please describe: ____

____

____

Do you have any allergies? ☐ Yes ☐ No

If yes, please describe: ____

____

____

Do you have any problems with vision or hearing? ☐ Yes ☐ No

If yes, please describe: ____

____

____

How many times per week do you generally exercise? _____________

What types of exercise do you participate in?____

____

Please list any difficulties you are experiencing with appetite or eating patterns: __________________________

____

How would you rate your current sleeping habits? (please select one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Please list any specific sleep problems you are currently experiencing: ___________________________________

____

____

Usual Bedtime:______________ How long to fall asleep? ____________

Do you sleep through the night? ☐ Yes ☐ No

If you wake, how long does it take to fall back asleep? _______________

Do you often take naps? ☐ Yes ☐ No

Do you have difficulty getting up in the morning? ☐ Yes ☐ No

Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, for approximately how long? ____

____

Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No

If yes, when did you begin experiencing this? ____

____

Are you currently experiencing any chronic pain? ☐ Yes ☐ No

If yes, please describe: ____

____

Have you had any previous involvement with the police or the courts? ☐ Yes ☐ No

If yes, please describe: ____

____

What significant life changes or stressful events have you experienced recently?___________________________

____

____

What prompted you to initiate AD/HD testing? ____

____

____

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.

CONSENT TO AUDIO/VIDEO RECORDING

The undersigned understands that sessions for assessments and evaluations may be audio recorded or video taped for note-taking purposes only. The audio/video will be stored in a locked cabinet and is subject to the same degree of confidentiality and security as medical records. If you do not agree to taping and/or recording of any sessions with the clinician, you will need to advise the clinician before the session begins. If you consent to audio/video recording, please initial to the right. **INITIAL______**

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 $140.00 per hour. If additional copies of the report are requested by the client, or on behalf of the client, there will be a fee of $25 per report. 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.

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

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 and Wellness Center.

STATEMENT OF UNDERSTANDING:

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

______________________________	______________________________
Client	Date
______________________________	______________________________
Witness	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 Therapist's Name

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.
Physician's Name

Contact phone number and address: ____

○ To disclose and discuss clinical and treatment information with,

___________________________ and/or ____
School Name Counselor(s) /Teacher(s)

○ To disclose and discuss clinical and treatment information with, ___________________________
Spouse/Other

please explain: ____

○ 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 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.

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Signature	Date