



NEW CLIENT INFORMATION

Date: _____

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

If minor name of Parent/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

If "no" please give mailing address: _____

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

Sex: Female Male Marital Status: Single Married Other

Current School attending (if minor): _____ Grade _____

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Date of Birth: ____ / ____ / ____

Employer: _____ Occupation: _____

Address(if different from above): _____ City: _____ State: ____ Zip: _____

Social Security #: ____ / ____ / ____

Sex: Female Male Marital Status: Single Married Other

ADDITIONAL PATIENT INFORMAITON

How did you hear about our office? Internet Doctor Other _____

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: _____ 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:

The fee for your initial (50 min.) session is \$ _____. Follow up sessions (50 min.) thereafter are \$ _____. Your regular fee will be charged for any 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 required to go to court 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 hours notice is required to give us ample time to fill your appointment. If you do not cancel within the 48 hours there will be a no show/late cancel fee of \$130.00 per hour. 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. Account balances more than sixty (60) days past due will be charged to the client's credit card.

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 balances past (60) days. 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 Pin _____

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 expire 90 days after the date signed unless another date is specified. 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.