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:

Your co-payment is ___________, your deductible (if applicable is) $ _________ then you are responsible for _______ co-insurance. You have ___________ EAP sessions available to you with the authorization number of ____________. 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 pf medical or other information is not sufficient for this purpose.