



Counselor: \_\_\_\_\_  
 Center for Family Development  
 14114 Dallas Pkwy, Ste. 245  
 Dallas, TX 75254 972.774.9595

Client Name: \_\_\_\_\_

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

### Adult Client Information

Name		Date:	
Home Address			
City		State	Zip
Home Phone		Cell Phone	
<b>I authorize the above named counselor to contact me at the above address and phone number(s):</b>		<i>signature:</i>	
Social Security #	Email address		Date of Birth
Age	Sex	Person financially responsible for account	

### Employment Information

Employed Full Time	Part Time	Student Full Time		Part Time	
Employer		School Name			
Work Address		School Address			
City	State	Zip	City	State	Zip
Work Phone		Alternate Phone			

### Relationship Information (to be filled out if you are filing under another's insurance)

Single	Married	Co-habiting	Divorced	Separated	Widowed
Name of spouse/partner			Name of Parent		
SS#	DOB		SS#	DOB	
Home Address			Home Address		
City	State	Zip	City	State	Zip
Home Phone			Home Phone		
Work Address			Work Address		
City	State	Zip	City	State	Zip
Work Phone			Work Phone		
Alternate Phone			Alternate Phone		





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<b>Physical / Mental Health Concerns</b>		
Current injuries/health problems		
Current medications prescribed		
Current or past mental health treatment		
Date	Name of doctor, psychiatrist, counselor, etc:	Diagnosis / outcome of treatment:
Suicidal/homicidal/delusional ideations		
Substance abuse history or current concern		

<b>Education and Career:</b>
Highest Level of Education (including majors, special areas of expertise or interest):
How satisfied are you with your current level of education?
Current job or career:
How satisfied are you with your current job or career?

<b>Relationship Information:</b>
How long have you been in this current relationship?
Previous separations?



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History of abuse
Children (name and age)
CPS involvement?
Who has legal custody?
Do you have any special concerns regarding your children?

<b>Present functioning</b>
Sleep
Appetite
Stress
Other Stressors

<b>Resources</b>
Family
Friends
Spiritual support
Support groups
Fun

<b>Legal Status</b>
Warrants
Probation/parole
Criminal history
History of civil / criminal lawsuits and complaints against businesses and service providers:



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**THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. EFFECTIVE DATE: October 1, 2007**

\_\_\_\_\_ (hereafter referred to as “this counselor”) recognizes the importance of confidentiality of client communications in the therapeutic and counseling process and agrees to treat confidential information in accordance with law and professional standards. Confidentiality is an ethical and legal concept, and certain exceptions to confidentiality exist.

**Use and disclosure of protected health information for the purposes of providing services.**

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow a provider to use and disclose your health information for these purposes. I understand that this counselor may communicate confidential information when permitted or required by law. Some of the exceptions to confidentiality include: 1) duty to warn and protect when a client threatens harm to self or others, 2) abuse of vulnerable adults and children (including prenatal exposure to controlled substances), 3) in the event of client’s death the client’s spouse or parents have a right to access their spouse or child’s records, 4) professional misconduct by a healthcare professional, 5) court orders, 6) minors/guardianship in which case parents/guardians have a right to access the client records, 7) when the client directs the counselor in writing to disclose information with other healthcare professionals or others, and 8) in connection with billing efforts or insurance verification and payment.

I authorize this counselor to consult with other professionals if needed in order to provide me with the best possible treatment. In such cases, my name and any other identifying information *will not be disclosed* and only clinical information about my case discussed. Also, if I participate in couple, group or family counseling, I understand that separate files are kept for confidential individual information including: a) testing results, b) information given to my therapist not in the presence of other person(s) utilizing services, c) information received from other sources about the me, d) diagnosis, e) treatment plan, f) individual reports/summaries, and g) information that has been requested to be separate. Material disclosed in conjoint family or couples sessions, in which each party discloses information in each other’s presence, is kept in each file in the form of case notes.

Specifically, I authorize this counselor the release of confidential information for the purpose of processing third party payor forms, including verifying insurance coverage, or when obtaining payment for third party payors, including processing claims and collecting fees and I specifically authorize that information be released to: \_\_\_\_\_

Specifically, I authorize this counselor to release such information about me which in her opinion is reasonably necessary to protect myself or others from risk of death or serious harm, including information regarding my sexually transmitted diseases. Said information may be released to whoever is reasonably necessary to accomplish protection. I further understand that it may be beneficial in the course of my therapy to release information to family members or others. I, therefore, specifically authorize the release of confidential information to the following:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



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

I understand that any and all of my confidential records are the property of this counselor. I understand that this counselor may be unavailable at times due to illness, emergency or vacation. At that time, I authorize this counselor to release information to her substitute personal representative. The term "information" as used in this release means all information contained in written records and also information known to this counselor which may be communicated verbally. By signing this release, I also give this counselor permission to release information regarding my minor child(ren).

- I give consent to inform my Primary Care Physician that this counselor is treating me.  
\_\_\_\_\_Yes \_\_\_\_\_No (If Yes, name/phone number\_\_\_\_\_)
- I give consent to inform my Psychiatrist that this counselor is treating me.  
\_\_\_\_\_Yes \_\_\_\_\_No (If Yes, name/phone number\_\_\_\_\_)
- I give consent to inform \_\_\_\_\_ that my therapist is treating me.  
\_\_\_\_\_Yes \_\_\_\_\_No (If Yes, name/phone number\_\_\_\_\_)

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF HIPAA DEFINED PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I hereby state that by signing this Consent, I acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out his health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

I understand that, and consent to, the following appointment reminders that may be used by the Provider:

- Yes  No – a postcard mailed to me at the address provided by me,
- Yes  No – telephoning my \_\_\_\_\_ phone and leaving a message on my voice mail or with the individual answering the phone,
- Yes  No – sending me an email at \_\_\_\_\_

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations. I understand I have a right to inspect and copy my medical billing records, but I will be responsible for any charges incurred in making copies. The provider may deny this request but will be required to offer an explanation for the denial.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this Consent. All requests to revoke consent must be in writing.

I understand that I have the right to complain about the Provider. I agree to contact the Provider first with any complaints and if not satisfied, I have the right to issue a complaint to the U.S. Department of Health and Human Services at 1-800-368-1019 without any fear of retaliation from the Provider.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me. I have read and understand the foregoing notice, and all of my questions have been answered to me full satisfaction in a way that I can understand.

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness

## AUTHORIZATION AND ASSIGNMENT

I request that \_\_\_\_\_ (hereafter referred to as "this counselor") provide psychotherapy services to me and if applicable, to my minor child(ren).

**About Counseling:** This counselor believes you, as the client, have the capacity to resolve your problems with this counselor's assistance in clarifying issues and exploring potential alternatives. The counseling relationship is a partnership where you, the client, are the best judge of your interests, desires and needs while the counselor offers training, experience and tools to assist in this process. Techniques used may include insight, experiential, cognitive-behavioral-therapy, family therapy, guided imagery, hypnosis, motivational interviewing, play therapy and homework you/your child(ren) will do on your/his/her own. The ultimate responsibility for change rests with the client. You have the right to decline any technique or procedure. As with any changes, the client may experience times of discomfort as you explore new styles of relating to others and yourself.

Length of treatment varies by goal and individual. You and this counselor will mutually agree on the goals of your treatment, and you right to terminate counseling at any time. This counselor does request that any termination include one week's notice.

All sessions will be in person. Although these sessions may be very psychologically intimate, the relationship is a professional one subject to applicable ethical guidelines. This contract will be limited to counseling sessions.

**Referrals:** If you or this counselor determine that a referral is needed, this counselor will provide alternatives including programs and/or other professionals who may be available to assist you. You will be responsible for contacting and evaluating those referrals. In some cases, coordination of professional services may be required. Any exchange of information will only be made with express written permission from you.

**Fees:** I agree to a fee of \$\_\_\_\_\_ per 50 minute session. All group sessions (other than couple and/or family therapy) are \$\_\_\_\_\_ per group. If I billing a third party payer, I agree to pay the co pay amount of \$\_\_\_\_\_ at the time the service is rendered.

I agree to pay \$\_\_\_\_\_ for missed appointment unless I provide this counselor with notice of cancellation 24 hours in advance. I understand that the missed appointments will be noted on the bill, and that third part payers (if applicable) do not pay for missed appointments, and I am responsible for paying for those missed appointments.

If this counselor is requested by me or subpoenaed by me or someone else to testify in any court related proceeding in which I am a party, I agree to pay the fee of \$\_\_\_\_\_ per hour for preparation and testifying time (including depositions) and \$.25 per page for record photocopying. If this counselor's testimony is required by another party, she will attempt to obtain payment from that party, however, the ultimate responsibility for payment is mine and I agree to pay all costs and time incurred prior to or at the time of testimony.

**Sole Proprietor:** This counselor and any other person who has an office in the same suite are practicing as sole proprietors, individuals. The arrangement is an office sharing arrangement only and is not a partnership or similar entity.

**Grievances:** If you are dissatisfied with the services provided by this counselor please talk to her about it. She cannot correct a problem if she does not know about it. If you have a complaint which cannot be resolved by discussion or referral, you may contact one of the Texas Department of State Health Services to file a complaint as follows:

written:           Complaints Management and Investigative Section  
                          P.O. Box 141369  
                          Austin, TX 78714-1369  
phone:             1-800-942-5540

AUTHORIZATION AND ASSIGNMENT

**I have had an opportunity to read this Agreement and I agree with all of the provisions contained in this agreement. I understand that if I have any reservations, I should not sign this Agreement.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature if Client is a minor

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_

AUTHORIZATION AND ASSIGNMENT

To: \_\_\_\_\_

In consideration of your undertaking to treat me, I agree to the following:

**Authorization to Release Information**

You are authorized to release any information you deem appropriate concerning my condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as result of professional services rendered by you, and I hereby release you of any consequences thereof.

**Assignment of Cause of Action**

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth below), and authorize you to prosecute said action either in my name or your names as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

**Authorization to Pay Directly to Provider**

To: \_\_\_\_\_

(Name of insurance company)

In consideration of the services rendered and to be rendered, I authorize and direct payment to the provider named above of any sum I now, or hereafter owe by any insurance company obligated to reimburse me for the charges for his services and to make payment directly to the provider based in whole or in part upon the charges made for services rendered. If my current policy prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o \_\_\_\_\_

14114 Dallas Parkway, Ste 245

Dallas, TX 75254

**Acknowledgement and Understanding**

I understand that if it is determined either:

(a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the provider, or make other provisions for the protection of the interests of the provider;

(b) If a liability claim exists, and my attorney refuses to agree to protect the interests of the provider, or if I have not engaged the services of an attorney; then, payment for services rendered by the above-named provider will be made on a current basis and my bill paid in full as soon as my liability claim is settled, or the passage of three months from my last session, whichever occurs first.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature if Client is a minor

\_\_\_\_\_  
Date



Client Name: \_\_\_\_\_

Date \_\_\_\_\_

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### YOUR RIGHTS AS A CLIENT

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1. You have the right to be treated fairly and with respect.
2. You have the right to ask questions at any point in the therapeutic process.
3. You have the right to know the policy concerning canceled appointments (as during vacations, illness, etc.).
4. You have the right to request another therapist and receive competent referrals.
5. All people, including your therapist, have biases and values. You have the right to a therapist who will acknowledge personal values and will not attempt to impose them on you. The job of the therapist is to help you find your own way.
6. You have the right to ask about your therapist's training, theoretical orientation, techniques, and supervised experience.
7. You have the right to ask about your therapist's policy regarding confidentiality. You have the right to grant or deny permission to your therapist to discuss your progress with others.
8. You have the right to know your therapist's policy regarding medication. A medical doctor (M.D. or D.O.) is the only person who can prescribe medication. You have the right to take or not to take medication, to discuss pros and cons of it, and to be involved in the decision. If you disagree with your therapist about whether you should take medication, you have the right to seek another opinion.
9. You have the right to discuss what is happening in your session with other people and to consider and accept or reject this feedback about your progress.
10. You have the right to have a consultation with another therapist if you wish. It is usually a good idea to discuss your wish for a consideration with your present therapist, whether or not your therapist agrees. If after such discussion you still wish to have the consultation, it is important for you to trust your own feelings and use your own judgment.
11. You have the right to stop counseling when you want, whether or not your therapist agrees with your decision. It is usually worthwhile to discuss with your therapist your reasons for wanting to stop your sessions. However, the decision is always yours.
12. In the event of an "emergency" you are encouraged to go to the nearest Hospital Emergency Room or to call Green Oaks Hospital at 972-991-9504. If you leave a message, your therapist will call you back as soon as possible.

**\*I understand and have received a copy of my rights as a client seeking therapeutic counseling services.\***

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date