Collin County Counseling

2150 S. Central Expy. Ste. 200

McKinney, TX 75070 • (469) 219-3256

# ADULT REGISTRATION FORM

Name: _____ DOB: ___/___/____ Age: _____

Residential Address: _____ City: _____ Zip: _____

OK to send treatment/billing information to this mailing address? ☐ Yes ☐ No

If no, please provide an alternative mailing address:

_____

Cell Phone: _____ Messages OK? ☐ Yes ☐ No

Email: _____

Relationship Status: Single * Married * Committed Relationship * Divorced * Separated * Widowed * Other

Emergency Contact: _____Relationship to you: _____

Home phone: _____ Other phone: _____

Primary Care Physician: _____Phone:_____

Referred by: ☐ Insurance Company ☐ Physician ☐ Friend ☐ Google:

**Financial Responsibility**—*If paying privately, please check here* ☐

Name of Insured: _____ Date of Birth: _____

Client's Relationship to Insured: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Child

Insurance Carrier: _____ Insurance Phone#: _____

Co-pay $_____ Member ID#: _____ Policy/Group#:_____

- Your signature below authorizes your insurance company to pay me directly for services provided.

- You are also authorizing the release of information about your care to your insurance company. The information often required by insurance companies may include, but is not limited to, diagnosis, prognosis and treatment goals.
- **If your insurance company should deny payment for any reason, you will be responsible for any outstanding financial debt associated with therapy services.**

Client: _____ Date:_____

# Office Policies and Informed Consent

Welcome! This document contains important information about my professional services and business practices and will serve as a therapeutic contract. Please read it carefully and jot down any questions you would like to discuss. Please let me know if you would like to receive a copy of this signed form for your own records

## About the Therapy Process

It is important for you to know that therapy has both benefits and risks. Therapy often requires recalling unpleasant events and struggling with troubling issues. Consequently, people sometimes experience uncomfortable feelings such as sadness or loneliness. However, therapy has been shown to have benefits for those who undertake it. Although there are no guarantees about the outcomes of therapy, people often report significant reductions in feelings of distress, satisfactory resolution of specific problems and an improvement in relationships and overall quality of life.

Due to the current COVID-19 circumstances, all the counseling sessions will be offered online as video session via a secure portal (HIPPA Complaint) or over the telephone based on client preference for the unforeseeable future.

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**Cancellation Policy**

**A 24 hour notice is required for changes in appointments.** Late cancellations and no-shows incur a **fee of $75.00**. This fee is not reimbursable by any insurance company and will be billed directly to the client.

**Payment and Fees:**

- Payment (private pay or co-pay) is due at the beginning of each session (cash or check).
- My standard fee is $150 for the Clinical Intake/hour and 135/hour for Individual, Marriage, and Family Counseling sessions. Longer/Shorter sessions will be prorated at $2.25/minute in addition to the fee.

- If using insurance, your co-pay is due at each session. Overtime fee for a session beyond the allowed time for Individual Counseling: 50 - 60 min & Family Counseling: 45 - 50 min will be prorated at $2.25/minute in addition to the copay. Please note overtime charge is client responsibility. Insurance/copay only covers for the above listed time limits per session.

- It is your responsibility to keep me updated with your insurance information. You are financially responsible for costs incurred when a claim is denied due to changes in, lapses or exhaustion of benefits or termination of coverage for any reason.

- Payment is due at the time services are rendered in the form of **cash, check or credit card**.
- A credit or debit card will be kept on file for copays or non-payment (insurance or client).

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**Other fees *not* covered by insurance: Client will be billed directly for these services:**

**Phone calls:** First **15 minutes–free; then $135/hour (pro-rated)**
**Over time Charges: $2.25/minute** for conversation going over the time limit in addition to fee/copay/deductible amount for a session
**Telephone consultation** with other professionals at client's request is **$135/ hour (pro-rated)** (i.e. psychiatrist, doctor, etc.)
**Other services:** (write letters, fill out forms**) $135/hour (pro-rated)**
**Legal:** attorney calls, reports **$150/hour**
**Preparation of Copies** of Client Records **$30.00**
**Returned Check Fee $35.00**

**Therapist Availability & Emergency Procedures:**

- Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions.
- You may leave a message for me at any time on my **confidential voicemail at:**
  **(469) 219-3256.** Messages left on weekends and holidays will be returned on the next business day. Non-urgent phone calls are generally returned within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message. I will return your call at my earliest opportunity.
- My office is *not* an emergency number. In the event of a mental health crisis, please call the **24 hour Crisis Line at (972) 233-2233.** You may leave a message on my voicemail regarding the situation and I will get back to you as quickly as possible.
- **In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

- Vacation: I will inform you in advance of my vacation schedule. I will arrange for coverage by another therapist if needed when I am out of the office for vacation or business.

**CONFIDENTIALITY**:

In most cases (see "Exceptions to Confidentiality" below) communications between client and therapist will be held in strict confidence - unless you provide your therapist written permission to release information about your treatment. If you participate in couples or family therapy, the therapist will not disclose confidential information about treatment to a third party (other than to a third-party payer) unless all treatment participants (18 or older) provide written authorization to release such information.

**Exceptions to Confidentiality**

Therapists are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Therapists are also required to break client confidentiality when it has been determined that a client presents a serious danger of physical violence to another person. A therapist may break confidentiality when she believes a client is likely to be dangerous to him or herself.

**Consultation**: I may consult with other professionals regarding my clients; however, my client's identity remains completely anonymous, and confidentiality is fully maintained.

**In my absence:** At times, I may need to reveal your name and phone number to particular therapists covering my practice in my absence.

**E - Mail Cell Phones, Computers and Faxes**:

Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone

communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality.

**Consent to Treatment:**

Your signature below indicates that you have had the opportunity to read and review the information in this document and that questions regarding your care have been satisfactorily answered. Furthermore, it indicates your willingness to abide by its terms and that you agree to participate in treatment. A copy of this document will be provided at your request.

**Client signature**

_____Date_____

## INTAKE QUESTIONNAIRE Name: _____

| What brought you into therapy today today? |
|---|
| |
| What do you wish to change or accomplish as a result of therapy? |
| _____<br>_____<br>Have you been in therapy before? ☐ Yes ☐ No If yes, please state when and where:<br>_____<br>Was it a positive experience? ☐ Yes ☐ No What did you like/not like about it?<br>_____ |

| **Reflecting on the last 6 months, please circle all that apply:** | |
|---|---|
| Frequently sad or depressed | Feeling restless or keyed up |
| Overwhelming worries | Restless unsatisfying sleep |

| | |
|---|---|
| Difficulty falling asleep or staying asleep | Muscle tension |
| Unable to concentrate | |
| Irritable and/or short temper | Mood Swings |
| Significant change in weight | Decreased need for sleep (only need 3-4 hrs) |
| Low energy level/fatigue | Feel more talkative than usual |
| Feeling excessive guilt or shame | Excessive spending/shopping |
| Unable to relax | Excessive gambling |
| Lack of appetite/increased appetite | Easily distracted by unimportant things |
| Loss of interest in activities/hobbies | Take too many risks |
| Feeling hopeless | |
| Feeling worthless | |
| Difficulty motivating | Troubling thoughts about the past |
| Withdrawn/isolating self | Nightmares |
| Cry easily/often | Startle easily |
| Difficulty making a decision | Too neat and orderly |
| Difficulty finishing tasks | Repeating certain behaviors over and over |
| | |
| Thoughts to hurt self | Easily upset or angered |
| Attempts to harm yourself | Feeling different from most people |
| Thoughts to hurt others | Shy around others |
| Threats to hurt others | Increasingly forgetful |
| | Strong fears |
| Feeling ill/sick | Difficulty with work or school |
| Stomach aches/vomiting | |
| Headaches/migraines | Use of sedatives |

**Medical History**

Have you consulted a physician or psychiatrist regarding the problem which brings you here? □ No □Yes

_____

Are you currently being treated for any medical problems? □ Yes □ No

Are you currently taking any medications? □ Yes □ No

List medications:

| Dosage | Type | For (i.e. depression) | Prescribed by |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you currently taking over the counter medications, herbs or supplements? □Yes□ No

Are you presently in good health? □Yes □ No

Do you engage in physical activity? □Yes □ No

If yes, what activity? _____ How often?_____

Do you smoke cigarettes (cigars, chew)? □ Yes □ No #_____per day

How much alcohol do you drink? #_____per day _____# per week

Do you drink caffeinated beverages? □ Yes □ No If yes, how many per day?_____

Do you use illicit drugs? □ Yes □ No

If yes, how often and what drugs do you use?_____

Have you ever tried to cut down or stop using alcohol or drugs? □ Yes □ No

Has anyone ever asked you to cut down on your drinking? □ Yes □ No

Have you ever been hospitalized for any emotional/ mental health condition? □Yes□ No

| |
|---|
| Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc) ☐ Yes ☐ No |
| Do you have a history of domestic violence? ☐ Yes ☐ No |
| Do you have a history of verbal, emotional or physical abuse? ☐ Yes ☐ No |
| Do you have a history of sexual abuse or sexual assault? ☐ Yes ☐ No |

**SUPPORT SYSTEMS**

| | | |
|---|---|---|
| Do you have one or two friends that you consider close and feel you can depend on? | ☐ Yes ☐ No | |
| Do have a religion or spiritual practice that you experience as supportive? | ☐ Yes ☐ No | |
| Do you belong to any social groups or participate in hobbies with people that you enjoy? | ☐ Yes ☐ No | |
| Is there a family member that you trust and can go to in times of emotional need? | ☐ Yes ☐ No | |
| Are there other people or aspects of your life that you consider supportive? | ☐ Yes ☐ No | |

**FAMILY HISTORY**

**Have you or anyone in your family, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.**

| **Has anyone experienced:** | **Family Member (s):** |
|---|---|
| Anxiety | |
| Depression | |
| Bipolar disorder | |
| Learning disorders (ADHD, dyslexia, etc). | |
| Illicit drug use | |

| | |
|---|---|
| Alcohol abuse | |
| Schizophrenia | |
| Anger | |
| Eating Disorder | |
| Phobias | |
| Hospitalization for Mental Health Condition | |
| Attempted or completed suicide | |

| **Please circle any of the following areas that you would like to address in therapy:** | |
|---|---|
| Family | Career/education |
| Parenting | Phase of life |
| Children | Stress |
| Relationships | Assertiveness |
| Alcohol or Drug use | Health Problems |
| Verbal abuse | Childhood experiences |
| Physical abuse | Loss or death |
| Emotional abuse | Spirituality |
| Sexual abuse | Self-esteem |
| Finances | Legal issues |

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# Credit Card Authorization Form

****It is the policy of this office to keep a credit card on file. The card information is kept safe and confidential. You may pay by cash or check, but a card must still be kept on file.****

**Name:**

_____

*Print Last* *First* *Middle Initial*

Name on Card if different

_____

**I authorize Collin County Counseling to charge my credit/debit card for professional services as follows:** *Initial*

_____ **All visits for which payment was not made at time of visit (this includes fee for service, deductibles and co-pays).**

_____ **To charge my card for the balance of fees not paid by my insurance company within 90 days.**

_____**To charge my card $75.00 for each no-show or late cancellation (less than 24 hours notice).**

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____

3-digit number on the **back** of the card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements:

_____

*Street* *City* *State* *Zip*

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**Card Holder Signature** _____, Date ____ /_____ /____