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: □ Physician □ Friend □ Google:

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

- Your signature below authorizes to collect payment directly from the authorized card on file for services provided.
- **If your existing card on file should deny payment for any reason, you will still 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.

Cancellation Policy

A 24 hour notice is required for changes in appointments. Late cancellations and no-shows incur a **fee of $150.00**. This fee will be billed directly to the client on the authorized card on file.

Payment and Fees:

- Payment (private pay) is due at the end of each session (credit card on file) on the day of the service.
- My standard fee is $150/hour for the Clinical Intake, Individual, Marriage, and Family Counseling sessions. Longer/Shorter sessions will be prorated at $2.50/minute in addition to the fee.
- Payment is due at the time services are rendered in the form of **credit card**.
- A credit or debit card will be kept on file for payment of services.

Other fees: Client will be billed directly for these services:

Phone calls: First **15 minutes–free**; **then $150/hour (pro-rated)**

Over time Charges: $2.50/minute for conversation going over the time limit in addition to fee amount for a session

Telephone consultation with other professionals at client's request is **$150/ hour (pro-rated)** (i.e. psychiatrist, doctor, etc.)

Other services: (write letters, fill out forms**) $150/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 online sessions 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 two business day. Non-urgent phone calls are generally returned within 48 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?

What do you wish to change or accomplish as a result of therapy?

_____

_____

Have you been in therapy before? □ Yes □ No If yes, please state when and where:

_____

Was it a positive experience? □ Yes □ No What did you like/not like about it?

_____

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

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.****

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 has to be made at the time of each visit (this includes fee for service/self-pay).**

_____ **To request an alternative credit card for the balance of fees not paid by my current debit/credit card on file at the time of service within 7 days.**

_____**To charge my card $150.00 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*

Card Holder Signature _____, Date ____ /_____ /____