New Client Information Sheet

Please complete **ALL** questions

PSY Family Services
301 W. Rosedale, Fort Worth, TX 76104

1. Client Demographics

Patient Name: Last:	First:	Middle:

Sex: ( )M ( )F	DOB:	Age:	School Grade:	Marital Status: ( )Single ( )Separated ( )Married ( )Divorced	Ethnic Origin: ( )Caucasian ( )African-Amer. ( )Amer. Indian ( )Hispanic ( )Asian

Address:	Apt. #:	City:	State/Zip:

Phone Number: ( )-	Social Security #:	Drivers License #:	State of License:

Employer Name:	Occupation:	Length of Employment:	Employer Phone Number: ( )-

Employer Address:	Suite #:	City:	State/Zip:

2. Emergency Contact

Emergency Contact:
Name:

Address:	Apt. #:	City:	State/Zip:

Phone Number: ( )-	Alternate Phone Number: ( )-	Relationship:

3. Referral Source

How were you referred to this office?

( )Insurance ( )Hospital ( )Mental Health Professional ( )Other:_____

4. Previous Counseling

Last 12 months: ( )Yes ( )No	When:	How Long:

Where:	Why:	If ended, why:

5. Health Insurance Information

Insurance Company:	Policy #:	Group Name:	Group #:

Insured's Full Name:	Sex: ( )M ( )F	Relationship:	DOB:

Employer Name:	Employer Phone Number: ( )-

Employer Address:	Suite #:	City:	State/Zip:

PSY Family Services

Assessment and Counseling Services
301 W. Rosedale, Fort Worth, TX 76104
(817) 338-4471

CLIENT INFORMATION AND CONSENT

Client's Name: _____ ***Date of Birth:*** _____

Consent to Treatment
I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. I understand that the session may be audio or video taped for educational purposes.

Appointments
Appointments are made by calling (817)338-4471. Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments.

Number of Visits
The number of sessions needed depends on many factors and will be discussed by the therapist.

Length of Visits
Therapy sessions are approximately 45-50 minutes in length. The charge for individual and family sessions is $75.00 per visit, unless there is an agreed-upon rate with your insurance. Different co-payments are required by various group coverage plans.

Assignment of Benefits
We will communicate with and work with your health/medical insurance for you. ***PSY*** will be assigned all medical and psychological benefits from insurance. ***PSY*** will release information necessary for payment to the paying agency. Your insurance carrier(s), including Medicaid, Medicare, private insurance, and any other health/medical plan, will issue payment directly to ***PSY*** for services rendered.

Confidentiality
Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons

mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible or providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel.

NAME **RELATIONSHIP** **TELEPHONE NUMBER**

_____

_____

_____

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

For clients that are under 18 years of age

Name of Parent/Guardian: _____ Relationship: _____

Name of Parent/Guardian: _____ Relationship: _____

If the client is under 18 years of age, please read carefully and initial each line to show your agreement:

_____ I agree that I am the Legal Guardian or Managing Conservator of the above-named client and have provided all available information regarding custody agreements applying to the above-named client.

_____ I give consent to ***PSY*** to provide counseling to the above-named client.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have read, understood, and agree to all the terms and information contained herein.

_____ _____

Client Date

_____ _____

Parent/Guardian Date

(if client is under 18 years of age)

Any inquiries/complaints about licensees from this office may be addressed by contacting the following:
Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369

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PARENT AUTHORIZATION, AGREEMENT, AND CONSENT FOR TREATMENT OF CHILD/MINOR

Client's Name: _____ ***Date of Birth:*** _____

When a child/minor is the primary client at our counseling office, it is essential that parents and/or legal guardians are in an agreement as to the decision to treatment, the treatment goals, appointment times, and the need to maintain client confidentiality. I understand that my child is the client, not the parent/guardian. This is true no matter who pay for the treatment of the child.

1. Are biological parents ___Married ___Separated ___Divorced ___Never Together
2. Who does the child live with the majority of the time? ___Mom ___Dad ___Other
3. Are there regular visits with the non-custodial parent? ___Yes ___No
4. Are biological parents both actively involved in Minor's life? ___Yes ___No
5. Are biological parents both in support of Minor receiving mental health treatment? ___Yes ___No

As a result, it is the policy of ***PSY*** that all minors presented for treatment have the following authorization and consent on file.

Please check the most appropriate box:

☐ **Both Legal Parents/Guardians Consent to Treatment (complete page 2)**

- Both legal parents/guardians agree to the treatment and providing of mental health services for their child and will indicate their consent below.
- If the biological or legally adopted parents are currently separated or going through the divorce process, both parents are still required to sign the **Client Information and Consent Form** before the child can be treated.

☐ **Divorce, Custody or Legal Issues (complete page 3)**

- Who is the Managing Conservator? ___Mother ___Father ___Joint ___Other
- Are there any step-parents who have been given authority by the court to consent for treatment of the minor? ___Yes ___No
- If there is an official certified divorce decree or a legal custody order that indicates that only one parent is legally permitted to determine and decide on the mental health treatment of the minor without the consent of the other parent, please provide our office with a **copy of the Court Order/Divorce Decree in its entirety**.

☐ **Missing or Deceased Parent (complete page 4)**

- The parent presenting the child for treatment has no access to the other parent due to the following reasons (death, in prison, missing, has left and made no contact, etc.) and therefore will acknowledge that they are the sole primary caretaker of the child for mental health treatment and will bare all responsibility for such consent.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

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Both Legal Parents/Guardians Consent to Treatment

Legal Parent #1 Name: _____

Relationship to Child/Minor: _____

I affirm that I have the authority to make healthcare decisions for _____.
(name of child/minor)

I am aware that all custodial parents and legal guardians must give consent before treatment begins. I understand and agree that any breach of these agreements may result in the termination of treatment services with ***PSY***. I am voluntarily signing this agreement.

_____ I agree that I am the Legal Guardian or Managing Conservator of the above-named client and have provided all available information regarding custody agreements applying to the above-named client.
_____ I give consent to ***PSY*** to provide counseling to the above-named client.

Signature: _____ Date: _____

Legal Parent #2 Name: _____

Relationship to Child/Minor: _____

I affirm that I have the authority to make healthcare decisions for _____.
(name of child/minor)

I am aware that all custodial parents and legal guardians must give consent before treatment begins. I understand and agree that any breach of these agreements may result in the termination of treatment services with ***PSY***. I am voluntarily signing this agreement.

_____ I agree that I am the Legal Guardian or Managing Conservator of the above-named client and have provided all available information regarding custody agreements applying to the above-named client.
_____ I give consent to ***PSY*** to provide counseling to the above-named client.

Signature: _____ Date: _____

Divorce, Custody or Legal Issues

Legal Parent Name: _____

Relationship to Child/Minor: _____

I affirm that I have the authority to make healthcare decisions for _____.
(name of child/minor)

I am aware that all custodial parents and legal guardians must give consent before treatment begins. I understand and agree that any breach of these agreements may result in the termination of treatment services with ***PSY***. I am voluntarily signing this agreement.

I understand that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreement, etc.

_____ I agree that I am the Legal Guardian or Managing Conservator of the above-named client and have provided all available information regarding custody agreements applying to the above-named client.
_____ I give consent to ***PSY*** to provide counseling to the above-named client.

Signature: _____ Date: _____

Missing or Deceased Parent

Legal Parent Name: _____

Relationship to Child/Minor: _____

I affirm that I have the authority to make healthcare decisions for _____.
(name of child/minor)

I hereby swear and affirm under any applicable perjury laws that there I no legal divorce decree, custody order, or separation agreement that restricts or limits me from making any or all decision in regard to my child's mental health treatment. I further acknowledge that ***PSY*** has asked and attempted to collect any and all such documents from me.

I understand that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreement, etc. I understand and agree that any breach of these agreements may result in the termination of treatment services with ***PSY***. I am voluntarily signing this agreement.

Signature: _____ Date: _____

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ASSIGNMENT OF BENEFITS AND INSURANCE RELEASE FORM

Client's Name: _____ ***Date of Birth:*** _____

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to **PSY** for any charges not covered by my healthcare benefits, as well as any applicable co-payments and deductibles. It is my responsibility to notify **PSY** of any changes in my healthcare coverage. In some cases, exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by **PSY** and/or my healthcare insurer if the submitted claims or any part of the claims, are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

Assignment of Benefits

I hereby assign all medical, mental health, behavioral health and substance abuse treatment benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to **PSY** for substance abuse/behavioral health treatment services rendered to myself and/or my dependent(s). I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **PSY** to: 1) Release any information necessary to insurance carriers regarding my illness and treatments; 2) To process insurance claims generated in the course of counseling and treatment; and 3) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Copy of Insurance Card/Verification

I understand that it is my responsibility to provide **PSY** with a copy of my current insurance card. It is also my responsibility to notify **PSY** of any changes to my insurance plan or insurance carrier.

_____ _____

Patient/Responsible Party Signature Date

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RELEASE OF INFORMATION

CLIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

By signing below, I hereby authorize ***PSY*** to Release and to obtain information with respect to any physical, psychiatric or drug/alcohol related condition obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare providers below. The type of information authorized for disclosures includes, but may not be limited to notification of admission/discharge, Psychiatric Evaluation, reports of Testing, discharge planning and summary, progress and treatment reports, physical exam, assessments, treatment content, treatment progress, payment records, social history, and any statements made by me to ***PSY***. The purpose of this disclosure is to identify persons supporting and using services, to aid in diagnosis, continuing care, and treatment.

Mental Health Professional (name, address, phone)

_____

_____

Primary Care Physician (name, address, phone)

_____

Psychiatrist (name, address, phone)

_____

Family / Parent / Guardian (name, address, phone)

_____

_____

_____

Insurance (name, address, phone)

_____

_____

Other (name, address, phone)

_____

_____

I have been advised that I may revoke this release of information at any time, except to the extent that information has already been released.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian *(if client is a minor under 18 years of age)* Date