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:

____

Home Phone: ______________________________ Messages OK? Yes No

Cell Phone: ______________________________ Messages OK? Yes No

Other phone: ______________________________ Messages OK? Yes No

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 Other:

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.

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.
- If using insurance, your co-pay is due at each 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.

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

Phone calls ………………**1st 15 minutes–free; then $135/ hour (pro-rated)**
Telephone consultation with other professionals at client's request………**$135/ hour (pro-rated)** (i.e. psychiatrist, doctor, etc.)
Other services (i.e. 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________________

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INTAKE QUESTIONNAIRE **Name:** ____________________

What brought you into therapy today 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. 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 $50.00 for each no-show or late cancellation (less than 24 hours notice).

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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 ____ /_____ /____