KINGWOOD

COUNSELING CENTER

P: (281) 608-1346 F: (832) 436-1648
1521 GREEN OAK PLACE SUITE 250 KINGWOOD TX,77339
INFO@KINGWOODCOUNSELING.COM
WWW.KINGWOODCOUNSELINGCENTER.COM

OFFICE POLICIES

Kingwood Counseling Center provides outpatient individual, family, and marital therapy to assist with resolution of issues related to relationships, anger, communication, self-esteem, grief, stress, and mental illness. Please feel free to discuss any questions you may have regarding treatment, treatment goals or policies.

APPOINTMENTS: Appointments are made by calling 281-608-1346. Appointments are 45-50 minutes long and the number of sessions will be determined by the patient and therapist. If your sessions are being paid for by insurance, sessions have to be approved by your insurance carrier. Regular appointments are important to produce maximum possible benefits, but you are free to discontinue treatment at any time.

PAYMENT: Your co-payment, or full payment if you are self-pay, is due at the time of each appointment. Credit cards are accepted for your convenience. The charge for court testimony is $125 per hour, including travel time to and from the court house or attorney's office.

CANCELLATION: If you need to cancel an appointment, please call the office at least 24 hours in advance. There is a $60 charge for appointments missed without 24 hour prior notice, unless there is a verifiable medical or family emergency and this fee will be charged to the credit card on file in the event of a missed appointment.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

1. Where there is a reasonable suspicion of child abuse or abuse to a dependent or elder person.
2. When the client communicates a threat of bodily injury to others.
3. When the client is suicidal.
4. There is physical injury due to violence.
5. When disclosure is required pursuant to a legal proceeding.

EMERGENCY PROCEDURES: In case of an emergency, call the office number and I will make every effort to return your call as quickly as possible. In the event of a clinical emergency, it is imperative that you call 911, your psychiatrist or go to the nearest hospital emergency room.

PATIENT INFORMATION

PLEASE FILL OUT COMPLETELY

Name: _____ SS#_____Date of Birth: _____

Age: _____ Gender: Male_____ Female_____

Address:_____City, State, Zip _____

Email: _____

Employer/School: _____

Occupation: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Where do you prefer to receive calls? Home_____ Work_____ Cell_____

Emergency Contact Name and relation:_____

Address: _____

Phone: _____

MEDICAL HISTORY

Allergies: _____Current Medications: _____

Primary Care Physician: _____Psychiatrist:_____

INSURANCE INFORMATION

Is this a work related injury/illness? Yes No

Primary Insurance:

Name of Carrier _____ Insured ID #: _____

Employer _____ Group #: _____

Address _____ Policy Holder: _____

City _____ State _____ Zip_____ Insured DOB: _____

Work # _____ Insured SS#: _____

Secondary Insurance:

Name of Carrier _____ Insured ID #: _____

Employer _____ Group #: _____

Address _____ Policy Holder: _____

City _____ State _____ Zip_____ Insured DOB: _____

Work # _____ Insured SS#: _____

ADULT CHECKLIST OF CONCERNS

IDENTIFYING INFORMATION Date :_____

Name: _____ Sex: _____ DOB: _____

Age: _____ Referral Source: _____

CHIEF COMPLAINT:

Presenting Problems: (check all that apply)

___Depressed/unhappy	___Impulsive	___Stressed
___Irritable	___Stubborn	___Stealing
___Temper Outbursts	___Lonely	___Lying
___Withdrawn	___Racing Thoughts	___Sexual trouble
___Daydreaming	___Unable to Relax	___Headaches
___Fearful/Anxious	___Relationship problems	___Palpitations
___Clumsy	___Can't keep a job	___Insomnia
___Overactive	___Financial Problems	___Appetite Disturbance
___Slow	___Self-mutilating	___Fatigue
___Short Attention Span	___Over-ambitious	___Child of an alcoholic
___Distractible	___Feel Inferior	___Trouble with the law
___Lacks Initiative	___Can't make decisions	___Drug use
___Undependable	___Strange Behaviors	___Alcohol use
___Shy	___Strange Thoughts	___Suicidal thoughts
___Phobic	___Memory Problems	___Prior suicide attempt(s)
___Occupational Problems	___Learning Problems	___History of abuse
___Poor impulse control	___Over-spending	___Risk taking behaviors

Other: _____

_____

What happened that makes you seek help at this time: _____

_____

Problems perceived to be: ___very serious ___serious ___not serious

What changes would you like to see in yourself: _____

_____

_____

AUTHORIZATIONS & ASSIGNMENTS FOR OUTPATIENT SERVICES

(Initial next to each paragraph & sign at the bottom of 2nd page)

_____**Application for Voluntary Services**: I hereby request outpatient services from Kingwood Counseling Center on a strictly voluntary basis. My reasons for seeking treatment are purely self-motivated and are free from any undue influence or outside forces and in no way constitutes any promise of exchange or social services.

_____**Authorization for Treatment**: I hereby authorize my therapist to treat my condition. I understand that no warranty or guarantee has been made to me as to the results that may be obtained. I understand that it may be the professional opinion of my therapist to refer me to a psychiatrist, psychologist, or another therapist as may be deemed necessary for additional consultation and/or evaluation. I understand that I may choose to accept or reject any recommendation and/or referrals made by my therapist.

_____**Waiver and Release from Liability**: I agree to abide by the rules and regulations of this office governing the use of the office and/or building facilities located at 1521 GREEN OAK PLACE SUITE 250 KINGWOOD TX,77339 & any other office location. I assume all responsibility for myself and my dependents or family members and release Kingwood Counseling Center, staff, agents, servants, governing bodies and professional staff from all responsibility for any event occurring during my use of these facilities and for my condition as a result thereof.

_____**Statement of Confidentiality**: I understand that any communication between my therapist and myself is kept in the strictest of confidence unless I have given expressed written and signed consent to the contrary. I also understand and agree that the following communications may not be held in confidence: plans for suicide, homicide, or known criminal activity. I hereby hold harmless and indemnify Kingwood Counseling Center for any breeches of confidentiality under such conditions.

_____**Consent to Verify Employment and/or Insurance Benefits**: I hereby authorize Kingwood Counseling Center to verify my employment and/or insurance benefits by contacting the personnel department at my place of employment or my insurance company directly.

_____**Physician, Psychologist, and/or Therapist Fees Billed Separately:** I understand that any outside Physician, Psychologist and/or Therapist fees are not included with those of Kingwood Counseling Center. I understand that I must contact each provider for any information regarding his/her fees and make necessary arrangements to pay each separately and directly.

_____I understand and agree that I, and any dependents seeking treatment, will be billed separately for each session. I also understand that I will be billed separately for individual, group, and/or family therapy sessions.

_____I understand that no session will be billed that has not taken place, but I will be billed for any scheduled session that I am not able to attend and do not cancel with Kingwood Counseling Center a minimum of 24 hours prior to that appointment time. Sessions not cancelled in advance will be billed at a rate of $60. I understand that I am responsible for keeping my appointments as scheduled, notifying the therapist in advance of need to reschedule, and paying the $60 cancellation fee should I fail to cancel prior to 24 hours before the appointment. Fees for cancelled appointments are billed to the client, not to the insurance company and will be charged to the credit card on file.

_____ I understand and agree that if Kingwood Counseling Center is to appear in court on my behalf, the charges for court testimony are $125 per hour including travel time to and from the court house. These charges are to be paid in advance, but no later than the day of the court testimony.

_____I understand and agree that payment is due at the time services are rendered unless other arrangements have been made with Kingwood Counseling Center. I may contact Kingwood Counseling Center during regular business hours regarding any billing questions.

_____I understand that should I have any questions, concerns or complaints regarding the therapeutic services provided by Kingwood Counseling Center, I may contact the appropriate state board of Texas. (If you do have any concerns or complaints, please bring them to our management first so we can make the neccecary changes to correct the issue.)

_____I have read the above and have had an opportunity to ask any questions I may have regarding the aforementioned. Furthermore, as indicated by my initials and my signature below, I fully understand and agree to these terms.

_____ _____

Printed Name of Client Date

_____ _____

Client Signature (age 16 or older) Date

_____

Signature of Responsible Party or Legal Guardian

_____

Signature of Provider and/or Witness

Acknowledgement of Review of Notice of Privacy Practices & of the Office Policies of Kingwood Counseling Center

I, _____, have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I have also reviewed this office's Office Policies and I acknowledge that I have received a copy of these documents.

Signature of Patient or Guardian/Representative Date

_____

Name of Patient

_____

_____

Description of Guardian or Representative's Authority
Note: This document will be placed in your medical chart and will become permanent medical record documentation.

CREDIT CARD AUTHORIZATION FORM

Please provide the following information:

Name on Card _____

Visa ___ MasterCard ___ Discover___ Amex___

Credit Card Number_____

Exp Date _____ Sec Code _____

Billing Address_____

City_____State_____Zip_____

_____ I authorize and agree for Kingwood Counseling to charge the credit card provided above for the amount of the co-pay determined by my insurance company.
_____ I authorize and agree for Kingwood Counseling to charge the credit card provided above for the amount of $100.00 per session should I be a self-pay client without insurance coverage.

_____ I authorize and agree for Kingwood Counseling to charge the credit card provided above for the amount of $60.00, should I fail to cancel with Kingwood Counseling Center a minimum of 24 hours prior to the scheduled appointment, as stated in the Authorizations & Assignments For Outpatient Services.

I understand that all the information provided will remain confidential and shall not be used for any reason other that those agreed upon above. I also agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

_____ _____
Signature Date

_____
Signature of Provider and/or Witness