**NEW CLIENT INFORMATION**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single \_\_ Divorced \_\_ Widowed \_\_ Married \_\_ Race: \_\_\_\_\_\_\_\_\_ Gender: Male \_\_ Female \_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or previous Military Service? \_\_\_Yes \_\_\_No # of Years: \_\_\_\_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatrist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_

Names of other family/friends living in household Sex Date of Birth Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Minor Clients:**

Primary Custodial Parent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom does the child reside? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-custodial Parent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*PLEASE NOTE: A COPY OF A CURRENT CUSTODY AGREEMENT IS REQUIRED PRIOR TO YOUR FIRST SESSION.**

How did you hear about us? Please check: Friend/Family \_\_\_ The Oaks Website \_\_\_ Psychology Today\_\_\_ Insurance Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We are happy to provide the benefit of filing Primary Insurance Only for our clients. The following information needs to be completed before the initial appointment. Please contact the number on the back of your card to verify your mental health benefits. Please note that mental health coverage and benefits may be different from medical benefits. If benefits have not been checked before the initial appointment, the client will be responsible for paying the full contract rate for their insurance company. You are responsible for any deductible or co-payment at the time of your session.

Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Provider phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Provider phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fees and/or co-payments vary according to insurance companies. In the event the insurance company fails to reimburse for services for any reason you are responsible for the entire fee. I understand that I am financially responsible to The Oaks Life Center for any charges incurred by myself and/or my dependents. I also understand that each family member participating in counseling services will require an initial assessment and diagnosis (if applicable) that will be filed with my insurance company.

**I authorize the release of any medical or other information necessary to process an insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to** **The Oaks Life Center**.

Initial \_\_\_\_\_\_\_\_\_\_\_\_

**Financial Consent & Accountability Statement**

It is our policy to charge a $100.00 fee for appointments that are not cancelled at least 24 hours in advance. If our offices are closed, you may leave notice of cancellation on our voice mail, which will note the day & time you called. For Monday appointments, cancellations can be left on our voicemail on the weekend 24 hours in advance. Your communication with our office about appointment cancellations allows us to offer that time to someone else who needs to be seen. I authorize The Oaks Life Center to keep my signature on file and to charge my credit card account for the following: (**There is a $2.00 service fee applied when using a credit card.)**

1. Balances of charges not paid within 30 days, but not to exceed $300.00.

2. Cancellation fee if an appointment is not cancelled within 24 hours.

3. If my card is declined for a no-show fee, I understand that the fee must be paid within 1 week or all future appointments I have scheduled will be cancelled.

I authorize outstanding balances not paid in 30 days to be charged to my credit card on file. I also authorize balances for charges not paid within 90 days to be sent to a collection agency. The Oaks Life Center is not required to notify me of this charge.

Type of Credit Card: Visa MasterCard American Express Discover

Name (as it appears on the card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_

Email Address where receipt may be sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I certify that my above information is true, accurate and I am an authorized user on the account. I authorize and agree to have my above credit card information kept on file and charged for co-pays, appointments not cancelled within 24 hours, no show appointments, and outstanding balances on my account. There is a $2.00 service fee applied when using a credit card.**

**Cardholder Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Briefly describe concern(s) that brings you to counseling at this time:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What changes would you like to see as a result of counseling?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous Mental Health Treatment: \_\_\_\_**Yes \_\_\_\_No

Therapist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide? ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for psychiatric/mental health or chemical dependency reasons? Yes \_\_\_\_ No \_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any current **medications & dosages**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any current **medical conditions**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past or Current Legal Issues\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past or current Military Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current occupation or school attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past 36 months has there been a death of a family member or someone close to you? Yes \_\_\_ No \_\_\_

If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spiritual/Religious identity growing up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Now: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your spiritual and religious practice today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fears and concerns of counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My biggest strength is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My biggest weakness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Goal or expectation of counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PRACTICE POLICY AND INFORMED CONSENT FOR SERVICES**

Thank you for choosing The Oaks Life Center for your counseling services. We understand that beginning the process of counseling may be a major decision and you may have many questions. This document is intended to inform you of The Oaks Life Center policies, state and federal laws, and your rights and responsibilities. If you have any questions or concerns, please ask and we will do our best to provide you with any information that you need.

**PROVIDER POLICY**

The Oaks Life Center is a group counseling practice. While every effort is made to accommodate a client’s request for a treatment appointment with a specific treatment provider, NOT all requests can be satisfied. **Clients of this practice understand that licensed counselors, interns under supervision and other providers provide their care.** Several of our therapists are also Board approved Supervisors. We also have counselors under supervision who have a master’s degree, hold a provisional license and must complete 3000 hours of counseling training as well as be supervised by an approved clinical supervisor. These counselors are under the supervision of Debi Mattocks, LCSW-S, Andrea Lowe, LCSW-S or Tiffany Turner, LPC-S.

**I have read, understand and accept the above PROVIDER POLICY \_\_\_\_\_\_\_\_\_\_\_**

(Client initials)

**DEPENDENT POLICY**

Persons younger than 16 years of age are only permitted in the office if accompanied by an adult at all times when not in family or individual sessions. Any member of our office staff reserves the right to immediately dismiss any person whom is considered to be disrupting office business or client care.

**I have read, understand and accept the above DEPENDENT POLICY** \_\_\_\_\_\_\_\_\_\_\_\_

(Client Initials)

**CANCELLATION POLICY**

It is our policy to charge a $100.00 fee for appointments that are not cancelled at least 24 hours in advance. If our offices are closed, you may leave notice of cancellation on our voice mail, which will note the day & time you called. For Monday appointments, cancellations can be left on our voicemail on the weekend 24 hours in advance. Your communication with our office about appointment cancellations allows us to offer that time to someone else who needs to be seen.

**I have read, understand and accept the above CANCELLATION POLICY** \_\_\_\_\_\_\_\_\_\_\_

(Client Initials)

**PAYMENT/FEE POLICY**

Current Fees include the following:

**Initial Diagnosis & Evaluation Session (1st Session)** $150.00 **Extended Sessions (80-90 minutes)** $175.00

**Regular Office Session (50 – 60 minutes)** $135.00

**If report preparation is requested** or required, the time rate charged for therapy sessions will apply.

**Phone Calls:** Only emergency phone calls are returned on a regular basis and only during office hours. These are

billed at $2.00 per minute and will be due at your next session.

**Payment of all fees and charges incurred by a client in this practice are the responsibility of that client.** Insurance claims will be filed at the request of a client **TWICE** as a **courtesy** to our clients. Any balance that is left unpaid following two attempts to recover such funds by submission of a claim to a third party or left unpaid 30 days following the date of treatment will be considered an outstanding balance. **Accuracy of claims submitted to third party payers is the responsibility of the client.** Payment of co-pay and all other charges are expected at the time of your visit, prior to seeing a provider.

**I have read, understand and accept the above PAYMENT/FEE POLICY** \_\_\_\_\_\_\_\_\_\_\_\_

(Client Initials)

**OUTSTANDING BALANCE POLICY**

Outstanding balances are defined as any balance due for services rendered at of our locations by any provider that has been left unpaid for 30 days following a date of service. **Payment of all/any outstanding balance incurred by a client is the responsibility of that client. While we routinely file insurance claims on behalf of our clients, the client who has received services is the sole responsible party for payment of any and all charges incurred over the course of their treatment.** In the event an outstanding balance occurs, the payment card that you provided will automatically be charged the full past due balance. The Oaks Life Center is not required to notify me of this charge. **There is a $2.00 service fee applied when using a credit card. Any outstanding balance owed to The Oaks Life Center is eligible to be sent to any collection agency chosen by this office and is considered a breech in the treatment contract, therefore is grounds for treatment contract termination.**

**I have read, understand and accept the above OUTSTANDING BALANCE POLICY** Client Initials \_\_\_\_\_\_\_\_\_

**CURRENT PAYMENT CARD POLICY**

A current and active payment card must be kept on file in the office for payment of any outstanding balance fees including outstanding balances and missed appointment fees. Clients agree to provide The Oaks Life Center with a current and active credit/debt card account information at the time of the initial appointment. It is the client’s responsibility to update this payment card information should the card expire or become inactive.

**I have read, understand and accept the above CURRENT PAYMENT CARD POLICY** \_\_\_\_\_\_\_\_\_\_\_\_

(Client Initials)

**NO SHOW POLICY**

We accept a limited amount of Medicaid Insurance from specific referral sources for children and adults. For all other clients, our office charges a $100.00 fee for all appointments that are not cancelled at least 24 hours in advance. Because we are unable to bill Medicaid or our clients using Medicaid for No-Show appointments, we provide referral sources to pursue counseling from another provider once a No-Show occurs.

**I have read, understand and accept the above NO SHOW POLICY \_\_\_\_\_\_\_\_\_\_\_\_\_**

(Client Initials)

**LIMITS OF THE COUNSELING RELATIONSHIP POLICY**

Although sessions with your counselor may be very intimate psychologically and interpersonally, the relationship is a professional relationship rather than a social one. Contact must be limited to sessions you arrange with your counselor. Due to ethical guidelines, you are asked not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references for you or relate to you in any way other than the professional context of the counseling sessions (this includes any interaction involving social networking sites). Again, in order to maintain proper ethical standards, when the counseling relationship ends, the limitations of contact with your counselor remain the same.

**I have read, understand and accept the Limits of the Counseling Relationship** \_\_\_\_\_\_\_\_\_\_\_\_

(Client initials)

**LIMITS OF CONFIDENTIALITY POLICY**

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

• criminal prosecutions

• child custody cases

• suits in which the mental health of a party is in issue

• situations where 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 the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying 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 consent, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing you mental health care services and payment for those services, and you are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result. I also give permission for my counselor to converse with other counselors in the group practice to provide the best possible treatment for myself.

**Duty to Warn**

In the event that the undersigned counselor reasonably believes that you are a danger, physically or emotionally, to yourself or another person, she has a duty to warn the person in danger and to contact your spouse, parent or emergency contact on your information form, in addition to medical and law enforcement personnel. Please discuss this with your counselor if you have questions.

**Incapacity or death**

I understand that, in the event of the death or incapacitation of your counselor, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my initials on this form, I hereby consent to another licensed therapist, selected by your counselor, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing,

**I have read, understood and accept the above LIMITS OF CONFIDENTIALITY POLICY**­­­ \_\_\_\_\_\_\_\_\_\_\_

(Client Initials)

**EMAIL/FAX/CELL PHONE POLICY**

It is very important to be aware that e-mail and cell phone communication can be accessed relatively easily by unauthorized people; hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your counselor **in writing** at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mails or faxes for emergencies or to send sensitive communication with your therapist. It is our policy NOT to release your client records directly to you or concerning a minor child. At any time, you may request to review your file with your therapist including explanation of diagnosis and treatment plan. If you request any type of report or summary of services to be sent, a written release must be signed and there is a fee of $75.00 - $300.00 depending on the type of report requested.

**I have read, understand and accept the above EMAIL/FAX/CELL PHONE POLICY \_**\_\_\_\_\_\_\_\_\_

(Client Initials)

**AFTER HOUR EMERGENCIES POLICY**

You may reach your counselor outside of office hours by calling 682-312-8184 and leave a message if there is no answer. Calls are returned in a timely manner. **If you have an urgent or life-threatening emergency, you should call 9-1-1 or go to the nearest hospital emergency room. You may also contact the 24 hr. Crisis Hotline at 817-335-3022 or 972-233-2233.**

**REFERRALS AND TERMINATION POLICY**

After the first couple of meetings, your therapist will assess if he/she can be of benefit to you. Your therapist does not accept clients who, in their opinion, they cannot help. In such a case, she will give you a number of referrals you can contact. If at any point during therapy your therapist assesses that she is not effective in helping you reach your therapeutic goals, she is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the psychotherapist of your choice in order to help with the transition. You have the right to terminate therapy at any time. If you choose to terminate services, your therapist will offer to provide you with names of other qualified professionals whose service you might prefer. You will be responsible for contacting and evaluating any referrals and/or alternatives.

**I have read, understand and accept the above REFERRALS AND TERMINATION POLICY** \_\_\_\_\_\_\_\_\_\_\_\_\_

(Client Initials)

**COURT/LITIGATION LIMITATION AND FEES POLICY**

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to **divorce and custody disputes**, injuries, lawsuits, etc.) neither you nor your attorney, nor anyone else acting on your behalf will call on the undersigned therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If, for some reason this agreement is disregarded and you subpoena a therapist working with The Oaks Life Center as a factual witness or involve them in any court related process, **a non-refundable retainer fee of $1500.00** will be charged to your credit card on file and a fee of **$250.00 will be charged for each additional hour** we are involved in case preparation, reports, phone calls, travel, waiting in court to be called and actual witness time. Fees are also required for copying old records or creating summaries or documents for court. All fees are due 24 hours prior to any court appearance.

**I have read, understand and accept the above COURT/LITIGATION LIMITATION AND FEES POLICY and Fees Policy**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client Signature)**

**CLIENT RIGHTS/GRIEVENCES POLICY**

Some clients need only a few sessions to achieve their goals. Others may require several months or even several years of counseling. As a client, you are in complete control of how many sessions you want to have in counseling. That means you can end our relationship at any time. We do ask that you come to a termination session. You have a right to refuse to do anything that makes you feel uncomfortable in a session. It is important that our services are rendered in a professional and respectful manner. If, at any time, you are dissatisfied with our services, please discuss any problem you have directly with us. We will work with you respectfully to resolve any issue you bring to our attention. If we are unable to resolve any issue, you may submit a grievance to:

* Texas State Board of Examiners of Licensed Professional Counselors
* Texas State Board of Examiners of Marriage and Family Therapists
* Texas State Board of Social Work Examiners

At the following common address:

P.O. Box 141369

Austin, TX 78714-1369 (1-800-942-5540)

**Communication Authorization and Release of Information to Family Members**

Do we, The Oaks Life Center, have permission to:

• Leave a message on your home answering machine regarding an appointment? \_\_\_YES \_\_\_NO

• Contact you at work regarding appointment changes, etc? \_\_\_YES \_\_\_NO

• Contact you by email regarding your appointment or bill? \_\_\_YES \_\_\_NO

• Discuss your appointment times with your spouse/parent/partner? \_\_\_YES \_\_\_NO

I acknowledge that confidentiality may not be maintained if text, e-mail or a cell phone is used pertaining to my Protected Health Information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name of Client Client or Representative Signature**

**ASSIGNMENT OF BENEFITS**

I authorize all insurance payments to be made to the designated provider or The Oaks Life Center. This assignment will remain in effect until revoked by me in writing. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my insurance company, or any balance due after payments by my insurance company. It is the patient’s responsibility to provide our office with the correct insurance information in order to file claims with the insurance company. Claims not paid due to incorrect information will then become the patient’s responsibility. **If you are more than 15 minutes late for your appointment, you will be responsible for the entire fee for the session, which is not reimbursable by insurance.** I understand that I am financially responsible to The Oaks Life Center for the charges incurred by myself and/or my dependents. Not filing insurance (you do not have to sign this segment)

**Client or Authorized Representative Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby agree to undergo mental health treatment by providers at The Oaks Life Center. I acknowledge that I have read and understood this practice policy and treatment consent. I accept and agree to abide by all of the stated and implied office policies as part of this treatment contract. I agree to engage in timely and courteous communication with the staff of The Oaks Life Center. I understand that my failure to communicate appropriately or comply with office policy in any way signifies a breach in the treatment contract. I understand that my breech in our treatment contract may lead to termination of services. My signature here signifies my informed consent to treatment, and I agree to all terms set forth in this document. I understand that I have the right to revoke this consent, in writing, at any time.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Signature or Minor’s Name ­­ Legal Guardian/Authorized Representative’s Signature Date**

**HIPAA**

**PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this consent. They are posted on our Website at [www.theoakslifecenter.com](http://www.theoakslifecenter.com) and posted in the office waiting area. The terms of our Notice may change, but if it is changed, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. The Oaks Life Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:**

* Protected health information may be disclosed or used for treatment, payment or health care operations.
* The Oaks Life Center has Notice of Privacy Practices posted on their website at [www.theoakslifecenter.com](http://www.theoakslifecenter.com) and in the office waiting area to ensure that each client has the opportunity to review this Notice.
* The Oaks Life Center reserves the right to change the Notice of Privacy Practices.
* The client has the right to request restrictions on certain uses of your information. However, The Oaks Life Center does not have to agree to those restrictions when legally unable to do so.
* The client may revoke this consent in writing at any time and all future disclosures will then cease unless required by law.
* The Oaks Life Center may condition receipt of treatment upon the execution of this consent.

**This consent was signed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature or Responsible Party Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to client**

**Coordination of Care**

The Oaks Life Center wishes to coordinate care with your Primary Care Physician and Psychiatrist. This may include diagnosis, lab work, medications and prognosis. We do this to ensure you receive comprehensive and quality health care. Please complete the information below so that we may have your authorization to coordinate care with your other providers.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date of Birth

authorize The Oaks Life Center to coordinate care with the following providers. I give my consent to release information.

**Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatrist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_

**Other Medical Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, the undersigned, understand that I may revoke this consent at any time to the extent that action has been taken in reliance upon it and that in any event this consent shall expire when I terminate services with The Oaks Life Center.**

**Client Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**