# KIM HUMPHRIES & ASSOCIATES

## CLIENT INFORMATION FORM

Name _____ Date____/____/_____

Street Address _____ DOB____/____/_____

City, State, Zip _____ Age_____

Contact information: Home ( )_____-_____ Work ( )_____-_____

Cell ( )_____-_____ **Please note which is best contact number: Home __ Work __ Cell __*

**Please indicate if we may leave a message. Yes ____ No ____*

Email _____

** Please note emails& texts are not encrypted. Therefore, we cannot guarantee confidentiality for these forms of communication.*

Occupation _____ Employer_____

Marital Status: S____ M____ D____ W____ Sex: M___ F___

Children (and ages) _____

Any previous marriages _____ If yes, when?_____ How long?_____

Custody of children by former marriage? _____

Religious preference _____

## INSURANCE INFORMATION

Name of Insured _____ DOB of Insured ____/____/_____

Client Relationship to Insured_____

Place of Employment _____

Name of Insurance Company _____

Insurance Address _____

City_____ State_____ Zip_____ Phone ( )_____-_____

Policy/ID Number #_____ Group # _____

**Authorization to Release Information** _____ ____/____/_____

(Without the above signature, insurance cannot be filed) (Signature) (Date)

Authorization to Pay Medical Benefits to Clinician _____ ____/____/_____

(Signature) (Date)

## Client Payment Contract

The client and counselor decide upon an appointment time that is mutually agreeable. Please note that **payment is due at the time services are rendered.** Please also not that **you will be charged at the full billing rate for cancellations made less than 24 hours in advance.** Because insurance companies do not cover the cost of canceled sessions, you are responsible for the full payment of cancellation fees. If you need to reschedule, please do so by calling **972-437-1400. Contacting by e-mail for cancellation will not insure 24 hours notice.**

If you miss two appointments without notifying the office, the therapist reserves the right to terminate the therapeutic relationship.

Although you are encouraged to telephone your counselor in an emergency, please be informed that you may be billed your regular rate for telephone calls in which you receive counseling.

If for any reason the therapist is asked to appear in court on your behalf, it is understood that his/her time incurred for such court appearances will be your responsibility.

## Payment Procedures

FEE INFORMATION: The standard fee for services is $155.00 per 45-50 minute session.

I have read and understood the above contract.

SIGNED: _____ Date: _____

_____ Date: _____

## Philosophy of Counseling

The philosophy of counseling used in this office is based on the following principles. The first will be to maintain the highest clinical and ethical standards. Second, the approach to therapy seeks to maintain Biblical integrity. While recognizing the client's belief system may differ from the therapist's, there is a commitment to recommending principles compatible with the Christian faith.

_____ Date: _____

Client consent

How much influence does religion have in your daily living?

1_____2_____3_____4_____5_____6_____7_____8_____9_____10
Not at all Very Much

Referred by _____
Previous therapy? Y____ N____ Date _____ Therapist_____
Current Medication _____
Inpatient Y____ N____ Outpatient Y____ N____ Where _____
Personal Physician _____ Phone (  ) _____
Date of last exam _____
Please indicate if there is additional medical and/or personal information not previously requested that you feel should be included _____
_____
_____

**RECORDS AND CONFIDENTIALITY**

All communication is confidential and your permission is necessary to release any information to outside persons except for the limitations required by the laws of the state of Texas. Exceptions to confidentiality may include (a) reasonable suspicion of incidents of child abuse or neglect, (b) incidents of elder abuse, (c) a determination that you are a danger to yourself or others, (d) a request from you in writing, directing the therapist to give a specified individual or agency information, or (e) the therapist is ordered by a court to disclose information.

Another exception would be in the event that your therapist is out of town or otherwise unavailable and another professional is providing emergency care for his/her clients; it is understood that this professional may need access to client files.

By signing below, you are indicating that you have read and understood this statement and that questions about this statement have been answered to your satisfaction.

Please note that emails and texts are NOT encrypted. Therefore, we can not guarantee confidentiality for these forms of communication.

I acknowledge that I have received a copy of the HIPPA privacy rule forms.

_____ _____
Counselor's signature Date

_____ _____
Client's signature Date

_____ (  )_____
Client's emergency contact Contact's phone number

*Texas State Board of Examiners of Professional Counselors*
*and Marriage and Family Therapists*
*1100 West 49th Street*
*Austin, Texas 78756-3183*
*(512) 834-6658*

*Texas Board of Social Work Examiners*
*1100 West 49th Street*
*Austin, Texas 78756-3183*
*(512) 719-3521*

Use check marks to indicate which of the following areas are currently problems for you.

**_____Stress**
**_____Worthlessness**
**_____Hopelessness**
**_____Feeling lonely**
**_____Experiencing guilty feelings**
**_____Suspicious feelings towards other people**
**_____Afraid of being on your own**
**_____Angry feelings**
**_____Low self-esteem**
**_____Feeling you don't belong**
**_____Concerns about physical health**
**_____Lack of self-confidence**
**_____Feeling fat even though your weight is below average**
**_____Eating and then vomiting to control weight**
**_____Concerns about finances**
**_____Feeling cut off from your emotions**
**_____Difficulty expressing emotions**
**_____Use of alcohol**
**_____Use of non-prescription drugs**
**_____Poor concentration**
**_____Getting grades that are lower than you want**
**_____Lacking assertiveness in some situations**
**_____Difficulty being open with other people**
**_____Difficulty communicating with boyfriend/girlfriend**
**_____Difficulty communicating with spouse**
**_____Difficulty making or keeping friends**
**_____Isolation/social withdrawal**
**_____Difficulty communicating with parents**
**_____Feeling pressured by parents' expectations**
**_____Feeling controlled/manipulated by parents**
**_____Thoughts of taking your own life**
**_____Thoughts of hurting yourself**
**_____Thoughts of hurting others**
**_____Difficulty living up to religious beliefs**
**_____Difficulty making decisions**
**_____Feeling guilty about sexual activities (past or current)**
**_____Difficulties in sexual relations with spouse**
**_____Disagreements with spouse concerning sex**
**_____Feeling attracted to members of your own sex**
**_____Physical abuse issues**
**_____Sexual abuse issues**
**_____Spousal abuse issues**
**_____Low energy**
**_____Anxiety/panic**
**_____Grief and/or loss**
**_____Delusions/hallucinations**
**_____Phobias**
**_____Obsessive/compulsive behaviors**
**_____Sleep disturbance (circle one: more sleep or less sleep)**
**_____Appetite disturbance (circle one: increased or decreased)**