NEW CLIENT INFORMATION

(Please Print)

Date _____/_____/_____

Client Name _____Gender_____Date of Birth ___/___/____

Address _____ City/State _____ Zip_____

Social Sec. # _____ (must complete to file insurance)

Home ( ) _____ Work ( ) _____ Cell ( )_____

Email Address:_____

Place of Employment:_____

How did you hear about us?_____May we contact your referral source? YES or NO? (circle one)

Circle One: Minor Single Married Partnered Divorced Separated Widow Living Together

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IF CLIENT IS A MINOR Legal Guardian's name_____

Address _____ City _____ State _____ Zip _____

Home ( )_____ Work ( ) _____ Cell ( ) _____

Per Texas Family Law, Custodial Parents must provide the most recent custodial agreement to protect the legal rights of the child. If you need to provide this document please bring a copy to your child's first session. Children will not be seen without this document in the file. Please initial if you are required to provide proof of custody. (_____) initial

HOUSEHOLD INFORMATION **(List all who live in the home)**

Name	Role (Husband, wife, child, partner, etc.)	Date of Birth
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____
		_____/_____/_____

INSURANCE & FINANCIAL INFORMATION

Insurance Company_____Phone (on back of card)_____

Primary Insured's Name_____*Their* Social Security #_____

Relationship to Patient_____I.D. Number_____

Date of Birth_____/_____/_____ Group #_____

Spouse's or Parent's Name_____SocialSecurity#_____

Street Address (if different from Patient's)_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____

Date of Birth_____Gender_____Marital Status_____

Employer_____Occupation_____ Years with Employer _____

Employer's Address_____

City_____State_____ Zip Code_____

*SECONDARY Insurance Company*_____*Phone (on back of card)*_____

*Secondary Insured's Name*_____*Their Social Security* _____

*Relationship to Patient*_____*I.D. Number*_____

*Date of Birth*_____/_____/_____ *Group #*_____

Client Name _____

EMERGENCY CONTACT INFORMATION

In the event of an emergency, please contact: Name _____

Address _____ Relationship _____

Home/Work _____ Cell _____

PRESENTING PROBLEM(S)

Please describe your reasons for seeking counseling (include month/year the problem started):

_____

Have you ever experienced suicidal thoughts or thoughts of harming self or others? Have you ever attempted suicide? If so, please explain:

_____

Was there an event which made these issues or problems begin? Yes _____ No _____
If yes, please describe: _____
_____

Please indicate the severity in which your problems are affecting the following areas:

	No effect	Little effect	Some effect	Much effect	Significant effect
Marriage/Relationships	1	2	3	4	5
Family	1	2	3	4	5
School/Job Performance	1	2	3	4	5
Friendships	1	2	3	4	5
Hobbies	1	2	3	4	5
Financial Situations	1	2	3	4	5
Physical Health	1	2	3	4	5
Anxiety level/Nerves	1	2	3	4	5
Mood	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleeping Habits	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5
Spirituality	1	2	3	4	5

Would you like your spiritual beliefs to be part of your therapy? If so, how? _____

Client Name _____

SUBSTANCE ABUSE HISTORY

Have you ever used drugs? Yes /No ___ What kind/How much? _____ How often? _____
Did you ever abuse alcohol? Yes /No ___ What kind/How much? _____ How often? _____
Do you drink coffee? Yes /No ___ How much? _____ How often? _____When did you start?
Do you smoke cigarettes? Yes /No ___ How many? _____ How often? _____When did you start?
Do you drink alcohol? Yes /No ___ What kind/How much? _____ How often? _____

MEDICAL HISTORY

Please list any prescription medication you currently use: (Name, dosage, frequency)

_____

Please list any over-the-counter medications you currently use: (Name, dosage, frequency)

_____

Describe any major illnesses or accidents you've experienced throughout your life:

_____

_____

Describe any medical or psychiatric conditions of your parents and/or siblings:

_____

Who is your primary care physician: _____

I give permission for SJCardwell Counseling & Consulting PLLC to contact my physician: Yes _____ No _____
Signature of Patient or Guardian: _____
Relationship of Guardian to Patient: _____
Date:_____
Do you have any allergies? Yes _____ No _____ Please describe any known allergies:_____

MILITARY HISTORY

Have you ever been a member of the armed forces? Yes____No____ Which Branch? _____
Have you been active in combat? Which? _____
Were you injured physically or psychiatrically? Yes ___ No _____
Where did you receive treatment? _____

PSYCHIATRIC HISTORY

Have you ever received psychiatric or psychological treatment before: Yes _____ No _____When?_____
What type of care did you receive? Inpatient _____ Outpatient _____ Both _____
Are you currently seeing a Psychiatrist? Yes _____ No _____ A Counselor? Yes _____ No _____
Psychiatrist's Name:_____ Counselor's Name: _____
Did your doctor prescribe medication? Yes _____ No _____ Prescription/Dosage _____

FEE POLICY

As a service to you, our office will verify your coverage including your deductible and co-payment, and out-of-network benefits if we are not a provider with your insurance company or third party carrier your benefits. We will file your insurance claims unless you tell us otherwise. **We request that you also confirm these provisions with your insurance company.** Your insurance policy is a contract between you and the insurance company. Therefore, you, as the insured, are responsible for payment of amounts refused or determined unnecessary by your insurance company. Occasionally, insurance companies misinform our office about patient benefits, and we do our best to acquire the correct information as soon as possible. All insurance benefits will be assigned to Susan J Cardwell, MA, LPC-S. This assignment will remain in effect until revoked by client in writing. Although it is possible that your mental health coverage deductible may have been met elsewhere, this amount will be collected until the deductible payment is verified by the insurance company.

Client Name _____

Clients are responsible for payment at the time of services. Court Testimony Fees are to be paid in advance with refunds provided if necessary. We accept cash, personal checks, MasterCard and Visa. **If we have not received verification of benefits from your insurance company at the time of your first appointment, the full fee will be charged.** If you have overpaid, you will be reimbursed.

OFFICE FEES

Insurance Code	Description	Time	Fee
90791	Intake	60 min	$110
90834	Individual Therapy	45-50 min	$95
90853	Couple/Family Therapy	45-50 min	$95
90853	Group Therapy	60-90 min	$40
Not Billable to Insurance	Late Cancelation/No show	n/a	$95
Not Billable to Insurance	Returned Check (NSF)	n/a	$40
Not Billable to Insurance	Consultation Services	60 min	$110
Not Billable to Insurance	Fees, Letters, & Reports	15 min	$25+
Not Billable to Insurance	Court Testimony, Preparation	30 min	$100 Paid in Advance

I understand that I am financially responsible to Susan J Cardwell, MA, LPC-S for the charges incurred by me and/or my dependents. My signature below acknowledges my total responsibility in paying for any fees not covered by my insurance company at the time of service.

Signed:_____Date:_____

Credit Card Authorization

I authorize Susan J Cardwell, MA, LPC-S to keep my signature on file and to charge my Visa/MasterCard account for recurring charges of ($_95.00_) for missed appointment or less than 24 hour cancellation notice.

I understand this authorization is valid for two years unless I cancel the authorization in writing. I promise not to dispute charges (charge back) for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize Susan J Cardwell, MA, LPC-S to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

Cardholder Signature: _____

Client Name: _____Cardholder Name: _____
Please Print Please Print

Cardholder Billing Address: _____

City: _____State:_____Zip:_____

Account #:_____Expiration Date: _____

Cancellation Policy

It is our policy to charge the FULL FEE for missed appointments or appointments that are not cancelled at least 24 hours in advance. If our offices are closed, you may leave notice of cancellation on voice mail. Time has been reserved exclusively for you, and your courtesy to notify of cancellations allows us to offer that time to someone else. **(_____)** initial

☞If a client misses two consecutive scheduled sessions without a legitimate reason, the client will be considered to have given a notice of termination of therapy. **(____)** initial

☞Crisis calls over five (5) minutes will be considered a telephone session and will be charged accordingly. (_____) initial

Release of Information Authorization to Third Party

I authorize Susan J Cardwell, MA, LPC-S to disclose case records, such as diagnosis, summaries, and other requested information, to the insurance company for the purpose of receiving payment directly to our office. I understand that access

to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. **(_____)** initial

Client Name _____

Authorization for Care of Records

In the event of the incapacitation or death of my counselor, I authorize the person my counselor has designated to handle my files/records to contact me and assist me in continuity of care, payment, and/or resolution files/records. **(_____)** initial

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices, (HIPAA), which explains how my personal health information will be used and disclosed. **(_____)** initial

Confidentiality

Our office protects the confidentiality of counseling sessions. A signed "Release for Information" form is required in order to release any information about a client. All information between counselor and client is considered confidential unless:

1. The client presents a physical danger to self or others.
2. The probability of client suicide.
3. Child/Elder/Disabled person abuse or neglect is suspected.
4. A judge signed court order has been issued.
5. The client is a non-emancipated minor – in which case the parents or guardians have the right to access the client's records.

In the first three cases, the counselor is required by law to inform potential victims and legal authorities so that protective measures can be taken. **(_____)** initial

Consent for Treatment

I certify that I have read this agreement and understand the office policies and hereby give my consent for Susan J Cardwell, LPC-S to provide me with counseling services. Individual sessions are up to 45 minutes long and group sessions are between 60 and 90 minutes long. The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings, understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others. Techniques may be used from a variety of theoretical backgrounds depending on your needs; Cognitive-Behavioral, Transactional Analysis, Client Centered, Relaxation/Imagery, etc. Referrals for medication evaluation or for psychological testing may be made to assist us in the best treatment available. It is your right to know your Diagnosis and Treatment Plan which will be available after the second session. **(_____)** initial

Professional Relationship

In order for your professional relationship with the therapist to be helpful and supportive, it must be free of any complications that might influence objectivity or taking unfair advantage of either party. For these reasons, business, personal, social media, or other outside relationships between the therapist and client are not permitted. This policy is in accordance with Texas State Board of Examiners of Professional Counselors Code of Ethics. It is vital to remember that therapeutic services can sometimes generate emotions such as anxiety or depression. Counseling may alter your view of an important relationship, and you may change your attitudes toward important people in your life. Such outcomes are possible when people are in psychotherapy, and these changes are to be processed during the sessions. The professional boundaries with your counselor must be maintained to insure his or her professional perspective on your issues.

_____

Client Name (Please Print)

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Signature of Counselor Date

An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:
Complaints Management and Investigative Section
PO Box 141369, Austin, TX 78714-1369

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