www.lascolinascounseling.com
1075 Kinwest Parkway, Ste 107
Irving, TX 75063
Tel: 972-910-8388

Client Information

Today's Date: _____ Name: _____
Date of Birth**:** _____ Social Security: _____ Email:_____
Home #: _____ Work #: _____ Cell #: _____
Please indicate where we may leave a message Home: ___ Cell: ___ Email: ___
Address: _____
City & State: _____ Zip: _____Sex: Male___ Female___
Marital Status: Single: ___ Relationship: ___ Married: ____ Separated: ___ Divorced: ____ Widowed: ___
Name of Spouse/Sig. other: _____
Children's Name(s) & Age(s) & Father/Mother of Children:_____
_____
Primary Care Physician: _____ City: _____
Employer: _____ Insured through Employer: Yes: ____ No: ____
Medical Insurance Co: _____*Member/Subscriber ID#:* _____
Primary Insured's Name & Date of Birth: _____

Emergency Contact
Name: _____ Home Phone: _____
Address: _____ Relationship: _____

Health Information
Please rate your health: Very Good ____ Good ____ Average ____ Declining ____
Recent weight changes: Lost _____ Gained _____
Date of Last physical exam: _____Report from most recent exam: _____
List all important past or present injuries, illnesses or disabilities: _____
_____
Are you currently taking any medication? *Circle:* **YES** **NO** Prescribed by: _____
If yes, please list them with dosages: _____
_____
Have you ever used drugs for other than prescribed medical purposes? *Circle:* **YES** **NO**
If yes please list them: _____
Have you ever had a severe emotional event? If so, please explain: _____
Have you ever terminated a pregnancy? If yes, when? _____
Have you ever had a miscarriage? If yes, when? _____

Religious/Faith Background
Current Faith involvement: _____
Please explain any recent changes in your spiritual life_____

Other Information

Are you willing to complete and sign a release of information so that your counselor may obtain social, psychiatric, or Medical information? *Circle:* **YES NO**

Have you ever been arrested? *Circle:* **YES NO**

If yes, please explain: _____

Have you recently suffered loss from serious personal, social, business, or other reversals? *Circle:* **YES NO**

If yes, please explain: _____

Have you ever been the victim of a crime? *Circle:* **YES NO**

If so, have you filed with Texas Crime Victims Compensation? *Circle:* **YES NO**

Identify any previous marriages: _____

Identify any history of psychiatric/emotional/drug or alcohol problems and treatments in your **current family** and in your **family of origin**: _____

_____

How did you hear about Las Colinas Counseling Center? _____

Education (Highest level completed): _____

Have you ever had any counseling or therapy before? *Circle:* **YES NO**

Outcome: _____

Please list names/dates of counselors: _____

Have you ever been in a residential or outpatient program for chemical dependency or psychiatric treatment? *Circle:* **YES NO**

If yes, please list facility, dates, and indicate if you completed the program successfully:

_____

_____

Please circle any of the following that describe your current thoughts & behaviors:

Aggressiveness	Mood Changes	Loss of Appetite
Anger	Nightmares	Nail Biting
Anxiety	Panic Attacks	Nervous Laughter
Confusion	Racing Thoughts	Lack of Self Care/Appearance
Crying	Restlessness	Procrastinating
Depression	Suicidal Thoughts	Pacing
Feeling Helpless	Compulsiveness	Smoking
Irritability	Grinding Teeth	Tapping
Impulsive	Hair Chewing/Pulling	Use of Alcohol
Lack of Concentration	Lateness	Use of Drugs

Acknowledgement of Receipt of Notice of Privacy Practices & Consent

I have received the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. (See HIPAA packet included for more details.)

Please READ and SIGN in the spaces provided below:

- I hereby consent for therapeutic services provided by Las Colinas Counseling Center, P.A.
- I authorize Las Colinas Counseling Center, P.A. and its agents to release information about me necessary to obtain insurance benefits and/or to receive payment and I understand that my signature requests insurance payments be made.
- I agree to provide the most up to date insurance information as soon as it is known, and am aware that I will be responsible for balances owed in the event this information is not provided within the insurances timely filing parameters.

_____ _____

Client's Printed Name Parent/Guardian (if applicable)

_____ _____

Client's Signature (Parent/Guardian if minor) Date

Spouse & Significant Other Communication: *(optional)*

Due to HIPAA rules and guidelines we are required to obtain authorization from you in order to provide information regarding scheduling & payment to anyone other than yourself. In the event you wish to share information other than scheduling and payment, we require a more detailed ***release of information form****. Please inform your therapist, and/or an administrative staff in the event this is the case.*

Please print **their** name, giving **your** consent by initialing **one or both** if you wish to provide your spouse or significant other access to these services. This will expire in one year from today's date ___/___/____ unless specified otherwise.

- *I authorize Las Colinas Counseling Center, P.A. to provide information to:*

_____ _____/_____/_____

PRINTED First & Last name (of Spouse/Significant Other) Date of Birth (of Spouse/ Significant Other)

regarding **scheduling** _____ & **payment**_____ only.

Your initial Your initial

Credit Card Authorization

Las Colinas Counseling Center requires all clients to provide a Credit Card on file for billing purposes.

This form authorizes Las Colinas Counseling Center to keep the following information on file for all services rendered including late cancellation/missed appointment fees, anything not covered by your insurance plan, as well as any other additional charges outside of my session fees.

Please READ and SIGN in the space provided below:

- I understand and agree that I am ultimately responsible for co-pays, deductibles, and/or the balance on my account for any professional services rendered.
- I understand that I am ultimately responsible to give a 24 hour notice in the event a scheduled appointment needs to be canceled and/or changed.
- I authorize Las Colinas Counseling Center, and it's agents to charge my card on record in the event I cancel a scheduled appointment with less than 24 hour notice.
- I authorize Las Colinas Counseling Center, and its agents to charge my card on record in the event that I miss a scheduled appointment & neglect to give any notice.

(See HIPAA packet included for more details)

Type of card: *Circle one*: **Master card / Visa**

Card number: _____

Expiration Date: _____ Security Code (3 or 4 digits on back of card): _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Name on Card: _____

Permission given over the telephone _____ (Admin or office staff Initial)

Electronic Receipt Requested: Y ___ N ___

If yes, E-Mail (of Payer): _____

*If someone else is paying on behalf of the client, please include a **signed release form** and the following:*

Client's Full Name: _____ Date of Birth: _____

Reason: _____

Please inform us prior to the start of the appointment if you wish to update your card on record, or use an alternative form of payment. Thank you!

_____ _____

Client's Printed Name Parent/Guardian (if applicable)

_____ _____

Client's signature (Parent/Guardian if minor) Date

Consent to Email or Text Usage

For Appointment Reminders and Other Healthcare Communications

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Las Colinas Counseling Center.

Please READ and SIGN in the space provided below.

- I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or email to receive communication as stated above.
- I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (please request revocation form from administrators).
- I understand that I can respond to the email or text message to confirm my appointment. I understand that I cannot respond to the electronic communication to cancel or change my appointment.
- I understand that if I need to cancel I must call the office one day before my scheduled appointment. I understand that failing to respond to the email or text message does not mean my appointment has been canceled. I understand that I may leave a voice message if I unable to reach the office staff directly.
- I understand that this is a service offered as a convenience, and understand I am ultimately responsible for any missed appointment fees regardless of whether I receive an electronic reminder or not.

Please choose the form of reminder you wish to receive: *Circle one only*: TEXT or E-MAIL

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders, feedback, information is _____.

_____ _____

Client's Printed Name Parent/Guardian (if applicable)

_____ _____

Client's Signature (Parent/Guardian if minor) Date

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I have received the office's Notice of Privacy (HIPAA document attached) which explains cancellation fees and additional charges outside of my session fees. I understand that I am entitled to receive a copy of this document, and can always obtain a copy when and if needed.