Las Colinas Counseling Center, P.A
1075 Kinwest Parkway, Ste 107
Irving, TX 75063
Tel: 972-910- 8388 Fax: 972-910-8366
www.lascolinascounseling.com

Fellowship Counseling at Watters Creek
825 Market Street
Building M, Suite 250
Allen, TX 75013
Tel: 972-910- 8388 Fax: 972-910-8366

Client Information
Date: _________ Name: _________________________________ Email: _______________________________
Home Phone: _______________ Work Phone: ____________ Cell #: ___________
Please indicate where we may leave a message Home: ______ Work: ______ Cell: ______Email: ________
Address: __________________________________ City: ___________________ Zip: _____________________
Date of Birth: __________ Sex: Male: _______ Female: _______ Social Security: ______________________
Marital Status: Single: ____ Relationship: ____ Married: _____ Separated: ____ Divorced: ____ Widowed: ___
Name of Spouse/Sig other ______________ Children's Name(s) & Age(s) ______________________________
____
Primary Care Physician: _______________________________ City: ___________________________________
Employer: _______________ Address: ____________________________ City: ____________ Zip: _________
Insurance: Yes _____ No ______
Primary Insured's Name & Date of Birth: ____
Medical Insurance Co: ______________________________Policy/Group ID#: ___________________________

Emergency Contact
Name: _________________________________ Home Phone: ____
Address: _________________________________Relationship: _______________________________________

How did you hear about Las Colinas Counseling Center? ______________________________

Education (Highest level completed) _______________

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? Yes ___ No ___ if yes please list them with dosages_______________

_______________________________________Prescribed by: ____

Have you ever used drugs for other than prescribed medical purposes? Yes ___ No ___ If yes please list them __

____

Have you ever had a severe emotional upset? 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

Have you ever been arrested? ____

Are you willing to complete and sign a release of information so your counselor may obtain social, psychiatric, or Medical information? Yes ___ No ___ please explain ____

Have you recently suffered loss from serious personal, social, business, or other reversals? Yes __________ No __________

Explain ____

Have you ever been the victim of a crime? Yes ___ No ___

If so, have you filed with Texas Crime Victims Compensation? 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**: ____
____

Personality Information

Have you ever had any counseling or therapy before? Yes ___ No ___ Outcome_________________________________

Please list dates and names of counselors:___________________________________ ___________________________

Have you ever been in a residential or outpatient program for chemical dependency or psychiatric treatment?

Yes ___ No ___ If yes, Please list facility and dates, and indicate if you completed the program successfully:

____

____

Please circle any of the following words which best describe you now: active, ambitious, self confident, persistent, nervous, hardworking, impatient, impulsive, moody, often-blue, excitable, imaginative, calm, serious, easy-going, shy, good-natured, introvert, extrovert, likable, leader, quiet, stubborn, submissive, lonely, self conscious, sad, fatigued, anxious, sensitive, other____

Consent

____________**Please read and initial in the space provided**. 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 have also read and received a copy of **CLIENT'S RIGHTS AND INFORMATION**, and I understand the **CANCELLATION** policy. __________ I hereby consent for therapeutic services provided by Las Colinas Counseling Center, and I authorize Las Colinas Counseling Center (and its agents) to release information about me necessary to obtain insurance benefits and/or to receive payment.___________ I understand that my signature requests insurance payments to be made and authorize release of information necessary to pay the claim.

____ ____

Client's Signature Date

____ ____

Counselor's Signature Date

I attest that I am the legal guardian or managing conservator of this minor child, _______________________________, with rights to consent medical treatment for this minor child and I do hereby consent for counseling services to be provided to this child. Signature of Guardian or Managing Conservator ____________________ Relationship_________________

CLIENT'S RIGHTS AND INFORMATION

When you come in for counseling, you are buying a service. Therefore, you need information to make a good decision. Below is general information about our practice, along with some questions you might want to ask about. You are entitled to ask your therapist about any of these questions, at any time. If you do not understand the answers please feel free to ask again.

I. Session Fees:

- Dr Cude -- $125
- Margaret Reddington -- $100 ($130 per family session)
- Michael Denson -- $100
- Shawn Boggs -- $100
- Linda Doak -- $100
- It is customary for co-payments/payment to be made at the time of the session. If there are financial needs to be considered, please talk this over with your therapist (e.g. a need to pay out the deductible or balance, etc.)
- Returned check fee is $25 for each returned check from your financial institution

II. **CANCELLATION/ NO SHOW POLICY:** Please be aware and understand that failure to call 24-hours in advance for cancellation of an appointment will result in your being billed a $50 fee. Your scheduled appointment has been set for you only. Please be considerate of others who may need help as well.

III. Insurance

We file in network insurance only. We can provide you with the necessary paperwork for filing insurance out of network.
If your insurance is to be utilized, you will be responsible for your co-pay and/or deductible.

IV. Records & Confidentiality

All of your communication becomes part of the clinical record, which is accessible to you in request. Your therapist will keep confidential anything that is communicated, with the following exceptions: a) you direct or give permission to tell someone else; b) your therapist determines that you are in danger to yourself or others; c) your therapist is ordered by the courts to disclose information; d) your therapist becomes aware of child abuse, elder abuse, or sexual impropriety by a doctor, minister, professional counselor, etc.

V. About Counseling: Counseling is a process that helps individuals, couples and families identify problems, establish goals, and identify pathways for achieving these goals. Counselors are trained to assist patients in changing troublesome and problem causing thoughts, feelings, behaviors, and relationships. Experience and research shows that patients who actively work on their problems both in counseling sessions and outside, and take responsibility for changing their own thoughts and behaviors are more likely to achieve their goals and receive more benefit from counseling than those who do not. As a client you have the right to refuse to participate in treatment or to terminate treatment at your discretion.

VI. This office uses a voice mail system in order to provide our patients with 24-hour access. The voice mail is checked many times during the day and evening in case emergencies arise.

Any person wishing to make a complaint concerning an ethical, legal or personal right violation may do so by contacting the Texas State Board of Examiners of Professional Counselors or the Texas LPC Board Phone is (512) 834-6658, LMFT Board Phone (800) 942-5540, or to the Professional Licensing and Credentialing Division (800) 832-9623.

Questions You May Want to Ask

I. About Therapy
   A. How often will we meet?
   B. About how many sessions will it take?
   C. What should I do if therapy isn't working?
   D. Will I have to take any tests? What kind?
   E. How does your kind of therapy work?
   F. What are the possible risks involved? (divorce, depression)
   G. What percentage of clients improve? In what ways?
   H. What percentage of clients worsen?
   I. What percentage of clients improve or get worse without therapy

II. Alternatives
   A. What other types of therapy or help is there? (support groups)
   B. How often do they work? What are the risks of these other approaches?

III. Confidentiality
   A. What kinds of records do you keep? Who has access to them? (Insurance companies, supervisors)
   B. Under what conditions are you allowed to tell others about the things we discuss?
   C. Do other members of my family, or of the group, have access to information?

IV. Appointments
   A. How are appointments scheduled?
   C. How long are the sessions? Do I have to pay more for longer ones?
   D. If you are not available, who is there that I can talk to?
   E. How can I reach you in an emergency?
   F. What happens if the weather is bad, or I'm sick?

V. Money
   A. What is your fee?
   B. How do I need to pay?
   C. Do I need to pay for missed sessions?
   D. Do I need to pay for telephone calls or letters?
   E. What are your policies about raising fees?
   F. If I lose my source of income, can my fee be lowered?
   G. If I do not pay my fee, will you take me to small claims court? Do you use a collection agency or lawyer? Under what circumstances?

VI. General
   What is your training and experience? Are you licensed? Supervised? Board Certified? Who can I talk to if I have a complaint about counseling that we can't work out?

The above information deals with most of the questions you will need to know, I will be happy to explain more about these issues and to answer other questions that you might have. This information will help you make your decision a good one. You can keep this information, and please read it carefully. We can look over it from time to time.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed 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.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient or Personal Representative