

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

**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 -- \$125 (\$155 per family session)
- Stephanie Van Wig -- \$100 (\$125 per couple or family session)
- Michael Denson -- \$100
- Linda Doak -- \$100
- Laura Robertson -- \$100
- Kimberly Daily--\$100 (\$125 per couple or family session)
- 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.

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Signature of Patient or Personal Representative

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Date

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Name of Patient or Personal Representative