Embrace Life Counseling & Consulting, LLC

Patient Information

Patient's Name: ____ Today's Date:___________________________

Birthdate: __________________________ Age: _________Soc. Sec. #: ____

Male ____ Female ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed _____

Address: ____

City, State, ZIP: ____ Referred by: _______________________________

Employer: ___________________________________ Occupation: ____

Home Phone: ___________________________________ Work Phone: ____

Cell Phone: _______________________________ Email: ____

Would you like to receive our email newsletter? Yes _______ No _______

What phone number/method is best for communication with you: Home _____ Work _____ Cell Phone _____ Email ______

In the event of an emergency whom should we contact:

Name: ____ Relationship: __________________________________

Cellular #_________________________ Work # ___________________________ Home # _________________________

Who Is Responsible for this account? Who is the insured?

Name: ____ Relationship to Patient: ________________________

Birthdate: __________________________________ Soc. Sec. # ____

Address: ____

City, State, Zip: ____

Insurance Co. Name and Policy #:____

Insurance Co. Phone # for Mental Health:____

Employer: ____ Occupation: ____________________________

Work #____________________________ Home #___________________________ Cell #___________________________

Authorization and Release:

- I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- I authorize/request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me.
- I am informed of HIPAA guidelines and regulations related to confidentiality of medical records.
- I agree to be responsible for payment of all services rendered on my behalf or for my dependents.
- I agree to notify your office more than 24 business hours in advance if I need to reschedule or cancel an appointment.

X____ ____________________

Signature of Patient or Responsible Party **Date**

*****Please Provide Your Insurance Card & Driver's License for Verification of Benefits and Identity*****

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Credit Card Authorization

(Credit cards are the preferred method of payment **or** we will need a check retainer on file.)

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee. An additional $25 fee will be assessed for 1.) returned checks, and 2.) inaccurately disputed charge-backs.

I, ____, hereby authorize Embrace Life Counseling & Consulting, LLC to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone and email consultations
- Appointments that I have cancelled with less than 24 business hours notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card/Debit Card Type (check one):

☐ Visa ☐MasterCard ☐Discover ☐American Express

Card #____ Expiration Date: ____________

Verification/Security Code (3-digit code on back of card by signature line): _________________

Name as Printed on Card: ____

Billing Address: ____

City: _________________________________ State: __________ ZIP: ___________________

By signing below I am authorizing Embrace Life Counseling & Consulting, LLC to bill my credit card at the usual fee for professional services as described above.

Signature: ____ Date: ____________

Print Name: ____

Embrace Life Counseling & Consulting, LLC

Patient's Informed Consent

❖**Please make no marks or add comments to this page of the document. It is your consent for psychotherapy services and your treatment is conditional on your signing this consent without modification.**

❖ I understand that the therapists abide by state and federal regulations regarding health and medical record keeping and confidentiality (most commonly referred to as HIPAA regulations) and that a copy of this document has been provided to me to review in the office and on the website.

❖I understand that if any assignment is given that I disagree with morally, ethically, spiritually, or emotionally, I have the right not to proceed with that assignment. I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.

❖I understand that there are some occasions when confidentiality can/must be breached. These are: a) I sign a Release of Information Form or I verbally direct my counselor to tell someone else, b) My counselor determines that his/her client poses a threat to self or others, c) My counselor is ordered by a court to disclose information, or d) My counselor suspects child/elder abuse has taken place and will notify Child/Adult Protective Services.

❖I understand that counseling can improve as well as upset the equilibrium in any person, relationship, or family.

❖I understand that if I have a complaint I cannot resolve with my counselor and I wish to file a formal complaint I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

❖**FEES:**I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay and that sessions are 45-minutes in duration, cost $100.00 per session (or the insurance contracted rate), and that all fees and co-pays are due at the time of service and account balances are not carried. Professional letters, short-term disability paperwork/forms, and other documents may be completed for a fee starting at $200.00 based upon the complexity of the task. I understand that there is a returned check fee of $25.00 and that if a returned check is not cleared up in 30 days my counselor will file a suit with the Harris County District Attorney's Office. I understand that if I do not give at least 24 business hours notice in canceling an appointment I will be charged the regular session fee and I must pay this fee before additional sessions may be scheduled.
The preferred method of payment is credit card but I may keep a check retainer on file with the provider's office.

❖I understand that my therapist is not a psychiatrist, he/she is a licensed Master's level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see a physician for a medical evaluation.

By signing below I confirm that I have read, agree to and received the above information.

____ ____________________

Patient or Responsible Party Signature Date Received and Read

Your treatment is conditional on your signing this consent without modification.

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ALL ABOUT YOU (THE PATIENT)

About Your Education:

Where did you attend public school? ____

Did you attend college/professional school? When, where, degree earned? ______________________________

____

Any plans to further your education? ________If so, when and what? ______________________________

____

About Your Relationships:

Please list your marriage(s) or other important "significant-other" relationships

	Spouse's name	Year Begun	Year Ended	Married to this person?	Children from this relationship and their ages
#1					
#2					
#3					
Please list all people who currently live with you					

About Your Family:

Relative	Name	Living?	Current age, or age at death	Occupation	Describe the Relationship
Father					
Mother					
Brother(s)					
Sister(s)					
Any other significant person?					

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ABOUT YOUR CONCERNS

Please check all of the items below that you currently experience or are having difficulty, and feel free to add any others at the bottom under "Other concerns or issues." You may add details as needed to clarify.

Abuse – emotional	Impulsive spending	Self abuse – burning
Abuse – neglect	Impulsiveness	Self abuse – cutting
Abuse – physical	Indecision	Self abuse – other
Abuse – sexual	Inferiority feelings	Self abuse – scratching
Aggression	Inhibitions	Self-centeredness
Anger	Interpersonal conflicts	Self-control
Anxiety	Irresponsibility	Self-esteem
Arguing	Irritability	Self-neglect
Attention Problems	Judgment problems	Separation
Career Concerns	Laziness	Sexual conflicts
Childhood Issues	Legal matters	Sexual desire differences
Children – care of	Loneliness	Sexual dysfunctions
Children – custody	Loss of control	Sexual – other issues
Children - management	Losses	Shyness
Choices I have made	Low energy	Sleep – insomnia
Codependence	Low frustration tolerance	Sleep – nightmares
Compulsive spending	Low income	Sleep – too little
Concentration problems	Low mood	Sleep – too much
Confusion	Marital coldness	Step-parenting
Crying	Marital conflict	Stress
Deaths	Marital distance	Stress-management
Debt	Marital infidelity/affairs	Suicidal thoughts
Decision making	Medical concerns	Suspiciousness
Delusions – false ideas	Memory problems	Temper problems
Dependence	Menopause	Tension/stress
Depression	Menstrual problems	Thought disorganization
Distractibility	Mixed feelings	Threats of violence
Divorce	Mood swings	Tiredness
Drug abuse – over the counter	Motivation	Tobacco use
Drug abuse – prescription	Mourning	Violence
Drug abuse – street drugs	Obsessions	Violence – victim of crime
Drug abuse – alcohol	Outbursts	Work problems
Eating – poor appetite	Oversensitive to criticism	Weight and diet issues
Eating – making myself vomit	Oversensitive to rejection	Withdrawal – isolating
Eating – overeating	Panic or anxiety attacks	Employment problems
Eating – under-eating	Parenting	Employment – lack of
Emptiness	Perfectionism	Employment – overdoing
Failure	Pessimism	Employment – termination
Fatigue	Phobias	**Other Concerns or Issues:**
Fears	Physical problems	
Financial troubles	PMS	
Friendship problems	Poor self-care	
Gambling	Procrastination	
Goals not being met	Relationship problems	
Grieving	Relaxation	
Guilt	Re-marriage	
Headaches, pains	Risk taking	
Health	Sadness	
Hostility	School problems	

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The following information is very helpful in case we need to contact your physician or psychiatrist. Please provide accurate contact information. Thank you very much for providing this so we may be of help to you.

About Your Health:

Who is your Medical Doctor? ______________________________ Last Visit: ______________

Phone/Address ____

Medical Concerns? ____

____

Prescribed Medications ____

____

Who is your Psychiatrist? ______________________________ Last Visit: ______________

Phone/Address ____

For what reasons/issues? ____

____

Prescribed Medications ____

____

Have you previously seen a counselor/therapist? __________ **Name:** ______________________

Phone/Address (if recent) ____

Reason for visits: ____

____

____

Do you have any chronic medical or mental-health conditions or concerns? __________. If so, please list: ____________

____

____

____

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had: ______________________

____

____

____

____

List **all other** medications or drugs (prescribed or street) you take or have taken in the last year:

____

____