DATE OF BIRTH

GENDER

 MALE FEMALE

PARENTS MARITAL STATUS

SINGLE MARRIED OTHER

HOME / CELL PHONE LEAVE MSG?

 YES NO

**CLIENT INTAKE FORM**

CLIENTS NAME

 **CLIENT INFORMATION**

EMPLOYMENT

EMPLOYED FULL TIME STUDENT PART TIME STUDENT OTHER

ADDRESS CITY/STATE/ZIP

EMERGENCY CONTACT NAME PHONE NUMER RELATIONSHIP

**People who currently live in your household:**

Name Gender Age Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What brings client to therapy? How long has the behavior presented itself? \_\_\_Days \_\_\_Weeks \_\_\_Months \_\_\_Years

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What/Who has made clients situation better?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What /Who has made clients situation worse?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have client been under the care of a psychiatrist, psychologist, or counselor? Yes No

If yes, please give the name, date, and location of therapy and briefly explain the nature of the problem which required attention:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Medical Conditions and Current Medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: (PCP/MD)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle any of the following struggles that pertain to the client:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ADHD | Depression | Hallucinations | Parenting | Social Withdrawal |
| Anger Dyscontrol | Disability | Health Problems | Personality Disorder | Sleep Disturbance / Insomnia |
| Anxiety | Domestic Violence | Loss/Grief | Physical AbuseAge of onset \_\_\_\_\_ | Suicidal ThoughtsAge of onset \_\_\_\_\_ |
| Bipolar | Drug/Alcohol Use | Marriage | Sadness | Work/Stress |
| Career Choices | Eating Disorder | Memory ProblemsAge of onset \_\_\_\_\_\_ | Separation/Divorce | Other: |
| Conduct Problems | Emotional AbuseAge of onset \_\_\_\_\_ | Obsessions /Compulsions | Sexual AbuseAge of onset \_\_\_\_\_ |
| Cutting / Self-Mutilation**APPOINTMENTS, CANCELLATIONS AND NO SHOW FEE** | Fears/Phobias | Panic Attacks | Sexual Problems |

***DATE***

We realize that on occasion you will not be able to make a scheduled appointment. You can call our office at 713-637-6000 and leave a cancelation message on the voice mail if no one is available. However, please remember that this time has been reserved for you alone, so our policy is to charge. **$50.00 for missed appointments or for cancelations without 24-hour advance notice.** No more appointments can be made until the No Show Fee has been paid, there will be no exceptions for this policy. Because we have many people who are waiting for appointments, clients who frequently (more than two times) fail or cancel their appointment without a 24-hour notice will not be rescheduled. Successful on-going therapy requires a commitment on the part of the client. It is important that you keep appointment if at all possible.

***SIGNATURE (S) RESPONSIBLE PARTY***

**BILLING INFORMATION - \*THE *PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT* IS FINANCIALLY RESPONSIBLE FOR PAYING FUND NOT PAID BY INSURANCE COMPANIES OR THIRD-PARTY PAYERS AFTER 60 DAYS.**

SUBSCRIBER

ID#

INSURANCE COMPANY

DOB

CARD NUMBER

EMPLOYER#

CVV CODE

EXP DATE



**PAYMENT METHOD - Self Pay/Insurance clients MUST have a credit card on file.**

I hereby give consent to charge my credit card below for any outstanding balance at the end of each month such as deductibles, co-payments or other amounts my carrier determines as payable by me.

***CARD HOLDER SIGNATURE***

CARD HOLDER NAME

***DATE***

**COURT & LEGAL PROCEEDINGS - Read and Initial**

***SIGNATURE (S) RESPONSIBLE PARTY***

**NSCC does NOT provide disability determination, custody studies, or handle court issues.**

**\_\_\_\_\_ NSCC providers do not perform court evaluations nor do they appear in court on behalf of individuals, children or adults**. NSCC services are designed to assist in alleviating problems through individual or relation psychotherapy. NSCC providers are not trained for, nor do they maintain records with the intended purpose of court involvement.

**\_\_\_\_\_ NSCC does not provide services that require "expert testimony decisions", regarding CPS, divorce, child custody and/ or visitation, nor disability cases.**

**\_\_\_\_\_** In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify however factual or in an expert nature, in court or deposition**.**

**\_\_\_\_\_** If you are requesting forms for determination of mental illness, disability, court involvement with custody or assessments to be completed, we would be happy to refer you to practitioners in the area who offer this service.

**\_\_\_\_\_** Should we be called to court by a judge court order or are subpoenaed, we will charge the full amount applicable under law for our services. Copies of records are available for a $20.00 processing fee, plus 1.00 per page for copying.

**\_\_\_\_\_** In the event that it is necessary,(by court order or by subpoena), for the therapist to testify before any court, arbitrator, or other **hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the** counseling relationship to a court official, the client agrees to pay the therapist for his or her services, including but not limited to: travel, necessary expenditures ( copies, parking, meals, and the like), time spent speaking with the attorneys, reviewing records and preparation of reports) @the rate of $ 250.00 **per hour**, rounding to the nearest half hour.

**\_\_\_\_\_** The client further agrees to pay a retainer fee of $ 2,000.00 **two weeks prior** to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

***DATE***

***DATE***

**PRIMARY INSURANCE INFORMATION**

GROUP#

***SIGNATURE (S) RESPONSIBLE PARTY***

RELATIONSHIP TO PATIENT

 SELF LEGAL GUARDIAN OTHER

RESPONSIBLE BILLING NAME

BILLING PHONE LEAVE MSG?

 YES NO

EMAIL ADDRESS

BILLING ADDRESS CITY/STATE/ZIP

**I clearly understand that I am ultimately responsible for payment to North Shore Counseling Center, Inc. for any and all services rendered due at the time of the visit.** I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. I understand that if I should default on any payment obligations, as called for in this agreement, North Shore Counseling Center, Inc. will have the right to forward my information to collections, and in the event that it becomes necessary to utilize a collection agency to resolve a past due account. My signature below indicates that I fully understand and agree to these terms.

***DATE***

***SIGNATURE (S) RESPONSIBLE PARTY***

I AUTHORIZE North Shore Counseling Center, Inc. to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to North Shore Counseling Center, Inc. regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify North Shore Counseling Center, Inc. immediately whenever I have changes in my health condition or health plan coverage in the future.

**PREPARATION OF FORMS AND REPORTS**

These require chart review and often, discussion with the client. There will be a minimum charge of $ 25.00 up to a maximum of $ 200.00 per hour.

*INFORMED CONSENT: My signature below indicates that I am consenting to treatment at North Shore Counseling Center, Inc., and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPPA).*

***DATE***

NSCC does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status.

Every client:

* shall be informed prior to, or at the time of, the intake appointment of the services that are available at NSCC and of any financial charges that will be the client’s responsibility to pay, beyond the coverage of health insurance.
* can expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
* shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his/ her treatment.
* shall have the freedom to place grievances and recommend changes in policies and services to NSCC staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, services offered by practitioners licensed by the State of Texas have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct.

Every Client:

* Has the right to be informed of and to refuse to participate in any experimental research.
* May expect courteous treatment and to be free from verbal, physical, or sexual abuse by NSCC staff.
* Has the right to a coordinated transfer of care when there will be a change of providers.
* May assert the client’s right (s) without retaliation.
* Has the right to choose freely among available mental health professionals and practitioners in the community and to change providers after mental health services have begun within contractual limits of the client’s health insurance (if any).

**CONFIDENTIALITY AND RELEASE OF RECORDS**

All information regarding patients is considered strictly confidential and will not be given out to anyone without your written consent. In the event of request for transfer of records, the records will be forwarded upon completion of a consent form and a payment fee based on the current TX Dept. of Health maximum allowed. Copies of records are available for a $ 20.00 processing fee, plus $1.00 per page for copying.

**CLIENT BILL OF RIGHTS**

**NOTICE OF PRIVACY PRACTICES (HIPPA)**

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients’ privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14,2003 and requires us to inform you of our policy. At NSCC we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment, for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services.

For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. One our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletter or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right the request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services 1100 Greens Parkway Suite 300 Houston, Texas 77067. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Owner, President, Linda Thompson.

***SIGNATURE (S) RESPONSIBLE PARTY***

**MINOR CONSENT AND AGREEMENT**

Please check below to indicate the current situation regarding the custody of the minor child:

 Parents are married to each other and are the legal parents of the child (*one signature required*)

**If parents are divorced and only one signature is present, a copy of the Custody Agreement court documents required a minimum of (1) business day prior to intake- copies of these documents must be present in the clients file (Court documents are also required when a guardian or the State has legal custody). I understand I cannot reschedule until I can provide appropriate documentation.**

 My ex-partner/spouse and I share legal custody of the child

(*both signatures required)*

 I am a single parent and have full legal custody of the child

 *(one signature required)*

The child is in the custody of the State of Texas:

County \_\_\_\_\_\_\_\_\_\_\_\_*Court documents are required at intake - a copy*

*must be present in the clients file.*

 I am a non-parent legal guardian and have full legal custody of the child (*one signature required*) Legal Guardianship court documents are required at intake. A copy must be present in the clients file.

* I understand that at least one parent must accompany the minor child to his/her first appointment and any subsequent appointments, until discussed with and agreed upon with the therapist.
* I understand that North Shore Counseling Center, Inc. does not give recommendations or do evaluations for child custody or parenting. If this becomes an issue, my child’s case may be closed.
* I hereby grant my permission for my minor child to be treated by North Shore Counseling Center, Inc. This permission will remain in force until revoked by me.

***LEGAL GUARDIAN SIGNATURE***

***LEGAL GUARDIAN SIGNATURE***

***DATE***

***DATE***

**MINOR AGREEMENT**

The involvement of children and adolescents in therapy can highly beneficial to their overall development. Very often it is best to see them with parents and other family members; sometimes, they are best seen alone. The therapist will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child’s caregivers is essential, as well as their understanding of the basic procedures involved in counseling children.

The general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, the therapist will evaluate and discuss these goals with you.

Because of the role is that of the child’s help, the therapist will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child’s therapist.

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time the parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and the child in therapy. This agreement regarding treatment of minors has provisions for inserting individual details, which can be supplied by both the child and the adults involved. However, it is first important to point out the exceptions to this general agreement. The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information.

Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is require to make an official report to the appropriate agency and will attempt to involve parents as much as possible.

I understand that the normal procedure for discussing issues that are in my child’s/children therapy will be joint sessions including my child/children, the therapist, and my and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present.

Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child’s/children well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

***DATE***

***SIGNATURE (S) RESPONSIBLE PARTY***