Westover Hills Counseling Center
New Client Registration Form / Policies / Fees / Insurance and Payment Information

(Boxes Outlined in Red are Required Fields)

Date

How Were You Referred?

Name of Referral

Contact Information - Person Setting Appointment

First Name

MI

Last Name

I prefer to be called

Street Address

Apartment #

City

State

Zip Code

Phone

Type

Ok to Call/Leave Message

◯ Yes

Date of Birth

E-Mail Address

Okay to E-Mail

◯ Yes

Appointment Reminders

☐ Cell Phone Text

☐ E-Mail

Emergency Contact

Phone Number

Relationship to You

Additional People (besides person above) **Attending Counseling Sessions**

Other Adult, Parent or Spouse

DOB

Relationship to You

Child or other

DOB

Relationship to You

Child or other

DOB

Relationship to You

Child or other

DOB

Relationship to You

Children under 18: You must provide a *copy of the custody or guardianship documentation if there has been a divorce or you are not the parent.* The *parent with custody or adult with guardianship must sign a Consent Form* authorizing counseling to children under age 18.

Type of Counseling Being Requested

☐ Personal ☐ Marriage/Relationship ☐ Family/Parenting/Child

Primary Counseling Concern

Secondary Counseling Concern

Please provide a brief note on your reason and goals for counseling

Previous Counseling?

☐ Yes

If so, when?

What was the counseling for?

How was this helpful or not helpful?

Relationship Status and Personal Information

Name (Person Setting Appt.)

Current Relationship Status

Date Relationship Began or Ended

If previous relationships, please list names, dates ended, reason

Children (list names, DOB, and if from a previous relationship, which partner)

Important Personal, Relationship, or Family History

Do you use:

- ☐ Alcohol
- ☐ Drugs
- ☐ Tobacco
- ☐ Prescription Meds

List Types, Amounts and Frequencies

Please list any physical concerns or illnesses

Describe how well and how much you sleep

What are your hobbies/personal interests?

What do you do for relaxation?

Describe your social life (friends, groups, activities, religious)

What is your occupation? Is it full time? How stressful? How satisfied are you with this job?

Name **OTHER ADULT INFO**

Current Relationship Status

Date Relationship Began or Ended

Address

E-mail Address

Okay to E-Mail

◯ Yes

Date of Birth

Phone

Type

Ok to Call/Leave Message

◯ Yes

If previous relationships, please list names, dates ended, reason

Children (list names, DOB, and if from a previous relationship, which partner)

Important Personal, Relationship, or Family History

Do you use:

- [ ] Alcohol
- [ ] Drugs
- [ ] Tobacco
- [ ] Prescription Meds

List Types, Amounts and Frequencies

Please list any physical concerns or illnesses

Describe how well and how much you sleep

What are your hobbies/personal interests?

What do you do for relaxation?

Describe your social life (friends, groups, activities, religious)

What is your occupation? Is is full time? How stressful? How satisfied are you with this job?

To Be Completed by Person Scheduling Appointment (or Child #1)

Symptoms Checklist

	Not at all	Sometimes	Often	Most of the time	All the time
I feel sad	◯	◯	◯	◯	◯
My future is not very bright	◯	◯	◯	◯	◯
I feel like a failure	◯	◯	◯	◯	◯
There is no joy in life	◯	◯	◯	◯	◯
I feel guilty	◯	◯	◯	◯	◯
I cannot do anything right	◯	◯	◯	◯	◯
I feel like I am being punished	◯	◯	◯	◯	◯
I don't like myself very much	◯	◯	◯	◯	◯
When things go wrong, it is usually my fault	◯	◯	◯	◯	◯
I think about killing myself	◯	◯	◯	◯	◯
I cry all the time	◯	◯	◯	◯	◯
I feel crying but, but I just can't anymore	◯	◯	◯	◯	◯
I feel so restless that I cannot keep still	◯	◯	◯	◯	◯
I feel stressed	◯	◯	◯	◯	◯
My emotions are hard to control	◯	◯	◯	◯	◯
I cannot stop thinking about things	◯	◯	◯	◯	◯
I isolate myself from others	◯	◯	◯	◯	◯
I feel anxious or experience panic	◯	◯	◯	◯	◯
I have difficulty staying focused	◯	◯	◯	◯	◯
I have difficulty making decisions	◯	◯	◯	◯	◯
I think about hurting others	◯	◯	◯	◯	◯

I have attempted suicide

◯ Yes

◯ No

If yes, how many times, when and how did you do it?

Your Name

To Be Completed by the Other Adult Attending Sessions (or Child #2)

Symptoms Checklist

	Not at all	Sometimes	Often	Most of the time	All the time
I feel sad	◯	◯	◯	◯	◯
My future is not very bright	◯	◯	◯	◯	◯
I feel like a failure	◯	◯	◯	◯	◯
There is no joy in life	◯	◯	◯	◯	◯
I feel guilty	◯	◯	◯	◯	◯
I cannot do anything right	◯	◯	◯	◯	◯
I feel like I am being punished	◯	◯	◯	◯	◯
I don't like myself very much	◯	◯	◯	◯	◯
When things go wrong, it is usually my fault	◯	◯	◯	◯	◯
I think about killing myself	◯	◯	◯	◯	◯
I cry all the time	◯	◯	◯	◯	◯
I feel crying but, but I just can't anymore	◯	◯	◯	◯	◯
I feel so restless that I cannot keep still	◯	◯	◯	◯	◯
I feel stressed	◯	◯	◯	◯	◯
My emotions are hard to control	◯	◯	◯	◯	◯
I cannot stop thinking about things	◯	◯	◯	◯	◯
I isolate myself from others	◯	◯	◯	◯	◯
I feel anxious or experience panic	◯	◯	◯	◯	◯
I have difficulty staying focused	◯	◯	◯	◯	◯
I have difficulty making decisions	◯	◯	◯	◯	◯
I think about hurting others	◯	◯	◯	◯	◯

I have attempted suicide

◯ Yes

◯ No

If yes, how many times, when and how did you do it?

Your Name

Insurance / Fees / Payment Information / Cancellation & Missed Appointment Policies

Insurance Company Name

Insurance Company Phone Number

ID Number

Group Number

Primary Insured Name (First, MI, Last)

Primary Insured DOB

Client Relationship to Insured

Primary Insured Street Address

City

State

Zip

Primary Insured Employer

Insurance Co-Payment/Co-Ins. Amount

I will not be using Insurance

◯ Not using Insurance

Session Fee

Insured's Phone #

Type

Person Responsible for Payment

Relationship to Person in Counseling

Sliding Scale of Fees (Based on Annual Gross Family Income) Please check your income range below:

◯ Below $40,000 Annual Income — Session Fee is $50

◯ $40,000 to $50,000 Annual Income — Session Fee is $60

◯ $50,001 to $65,000 Annual Income — Session Fee is $70

◯ Above $65,000 Annual Income — Session Fee is $75

I understand and agree that the insurance co-payment payment or the agreed upon per session fee is due at the time of service. Your counselor will let you know what forms of payment they accept. I understand that there is a *fee of $25 for returned checks and that this is in addition to* the original fees agreed upon.

I understand that cancelling my appointment with less than 24 hours notice, or missing an appointment will incur a charge of the full agreed upon hourly fee, unless this fee is reduced or dismissed by your counselor. If there is a credit card on file, this card will be charged that amount.. These fees are the not covered by insurance, and additional appointments may not be scheduled until payment is arranged.

There may be additional fees for requested reports, letters verifying counseling, counseling assessments and court appearances. Please speak with your counselor about these fees.

By typing my name, date and phone number below I understand and agree to the Fees listed on this page.

Name of Person Responsible for Payment

Date

Phone Number

Guidelines for and Limits of Counseling Confidentiality

Counselors are permitted and in certain conditions required to release personal and confidential information under the following conditions:

~ **When required by law.** We may use or disclose your health information as required by the state or federal authority.
~ **To report suspected child abuse or neglect.** We may disclose your health information to a government authority if necessary to report abuse or neglect of a child.
~ **To address a serious threat to health or safety.** We may use or disclose your health information to medical or law enforcement personnel if you or others are in danger and the information is necessary to prevent physical harm.
~ **To a government authority if it is reported that you are a victim of abuse.** We may disclose your health information to a person legally authorized to investigate a report that you have been abused, neglected, or have been denied your rights.
~ **For public health and health oversight activities.** We will disclose your health information when we are required to collect information about disease, or injury for public health investigations, or to report vital statistics.
~ **For purposes relating to death.** If you die, we may disclose health information about you to your personal representative and to coroners or medical examiners to identify you or determine the cause of death. We may also disclose information about you for burial purposes, including grave marker inscription, unless you tell us not to.
~ **If you are in the criminal justice system.** We may disclose your health information to other state agencies involved in your treatment, rehabilitation, or supervision.
~ **To your legally authorized representative (LAR).** We may share your health information with a person the law allows to represent your interests.
~ **In judicial and administrative proceedings.** We may disclose your health information in any criminal or civil proceeding if a court or administrative judge has issued an order or subpoena that requires us to disclose it. Some types of court or administrative proceedings where we may disclose your health information are:

> *Commitment proceedings* for involuntary commitment for court-ordered treatment or services
> *Court-ordered examinations* for a mental or emotional condition or disorder
> *Proceedings regarding abuse or neglect* of a resident of an institution
> *License revocation proceedings* against a doctor or other professional

~ **For national security.** We will disclose your health information if necessary for national security and intelligence activities, and to protect the president of the United States.
~ **To the Secretary of Health and Human Services.** We must disclose your health information to the United States Department of Health and Human Services when requested in order to enforce the privacy laws.

A counselor may only disclose information about your treatment for alcohol or drug abuse without your permission in the following circumstances:

~ Pursuant to a special court order that complies with 42 Code of Federal Regulations Part 2 Subpart E;
~ To medical personnel in a medical emergency;
~ To report suspected child abuse or neglect;
~ To Advocacy, Inc. and/or the Texas Department of Protective and Regulatory Services, as allow by law, to investigate a report that you have been abused or have been denied your rights.

I understand that I will be given a printed copy of HIPAA guidelines and confidentiality guidelines when I attend my first counseling session.

By typing my name and the date below, I agree that I have been made aware of the limits of confidentiality.

Full Name

Date