CLIENT INFORMATION

Dorothy J. Phillips, LCSW

PATIENT INFORMATION	REFERRED BY:
Name:	SSN:
Address:	Driver's License:
Street Apt.	
	Date of Birth:
City State Zip	
Phone:	Age:
Home Cellular	
Email:	

RESPONSIBLE PARTY INFORMATION	Same as Patient ☐
Name:	SSN:
Address:	Driver's License:
Street Apt.	
	Date of Birth:
City State Zip	
Phone:	Age:
Home Cellular	
Email:	

EMPLOYMENT INFORMATION	
Employer:	Occupation:
Address:	Office Phone:

EMERGENCY CONTACT In the event that the therapist reasonably believes that I am in danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following person(s), in addition to medical or law enforcement personnel as necessary.

Name:	Name:
Address:	Address:
Street Apt.	Street Apt.
City State Zip	City State Zip
Phone:	Phone:
Home Cellular	

ASSIGNMENT OF BENEFITS	
I hereby authorize my insurance benefits to be paid directly to Dorothy J. Phillips, LCSW and I understand that I am financially responsible for all non-covered services. I also authorize the provider to release any medical information required in the processing of claims. I understand that I am responsible for the payment of all charges regardless of insurance benefits.	
Client Signature	Date

PLEASE COMPLETE ALL FOUR PAGES

BRIEF HISTORY

Client Name	**Education / Last grade completed**

FAMILY HISTORY	Name	Age	Mental Health History
MOTHER			
FATHER			
SIBLINGS			
CHILDREN			

Marital History (Please include any previous marriages)			
Name of Spouse	Age	Marriage/Divorce Dates	Condition of Marriage

Psychiatric & Medical History
List prior counseling, psych hospitalizations, chemical dependency treatments and dates::
List any chronic medical conditions and treating doctor:
List any medications taken on a daily basis, include PRN:

FEES, CANCELLATION AND OFFICE POLICY

- Payment for Professional Services is due at the time of the schedule appointment. This clinician is required to specify that the fee for the initial session is $150.00 and fee for subsequent sessions $125.00. The Missed Session Fee is $75.00, payable prior to or at the next scheduled appointment. Invoices and collections are handled through this clinician's billing office.

  _____ (Initial here)

- Regarding insurance coverage, I understand a copay of $_____ is payable at each session. If an annual deductible $_____ must be met, I understand I am responsible to pay the full session fee until the deductible is satisfied. I understand that if my insurance company refuses payment even though the session was certified and the claim file correctly, I agree to pay the amount due.

- Scheduling an appointment involves the reservation of time specifically for your exclusive use. Any cancellation where 24-hours or more notice is not given by phone, regardless of reason, is charged the Missed Session Fee. Insurance cannot be billed when the insured is not present. Missed appointments can be disruptive to the therapeutic relationship and any missed appointment remains your financial responsibility unless at least 24-hours' notice has been given.

- I understand that if I fail to attend two consecutive sessions without 24-hours' notice, or if I consistently cancel appointments, the behavior could result in termination of the therapist's psychotherapy service.

POLICIES (Continued)

OTHER FEES: A $25.00 fee is assessed for each set of forms requested by the client to be complete by the clinician.

There is a $30.00 fee to process returned checks, payable prior to next scheduled session

I understand that in the event disclosure of my records or therapist testimony is required by law, I will be responsible for and shall pay the cost involved in producing those records at $1.00 per page ($25.00 minimum – payable in advance). The therapist will be pay $300.00 per hour (minimum 3 hours – payable in advance) for the time involved in preparing for, travel time, and giving testimony.

TELEPHONE: There is a voice mail system on at all times to take your calls. All calls are returned as soon as possible; typically, in less than 24 hours. In case of a medical emergency be sure to call 9 1 1.

CONFIDENTIALITY: You are protected by the confidentiality laws in Texas which state that anything you say during treatment is privileged information and cannot be shared with anyone else without your prior consent. This also means that the therapist cannot tell anyone without your permission whether you are in treatment or whether the therapist knows of you. This is not intended to be an inconvenience, however, your privacy must be protected in every way possible.

Possible exceptions to confidentiality include, but are not limited to the following situations: harm to self or others, reports of abuse or situations where the therapist has a duty to disclose.

CONSENT TO TREATMENT: I, voluntarily, agree to receive mental health assessment, care, treatment or services, and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand that therapy is about change and I may experience and confront issues that bring up very intense feelings including sadness, anguish, anxiety, or pain. I understand and agree that I will participate in the planning of my care, treatment or services and that I may stop such care, treatment or services that I receive through this therapist at any time.

I give my permission for the therapist or office staff to call and leave messages at my home, cell, or place of business. I also give permission for letters and bills to be mailed to my home address. I consent to the use of my email address for necessary correspondence.

NOTICE OF PRIVACY POLICY: I acknowledge that I have received a copy of the HIPAA Notice of Privacy Policy for Dorothy J. Phillips, LCSW.

By my signature below, I, the undersigned client, acknowledge that I have both read and understood all of the terms and information contained in this Client Information Form. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. All of the information provided is accurate to the best of my knowledge.

Client Signature	Date