CLIENT INFORMATION

Dorothy J. Phillips, LCSW

PATIENT INFORMATION	REFERRED BY:
Name:	
Address:	Driver's License:
Street Apt.	
	Date of Birth:
City State Zip	
Phone:	Age:
Home Cellular	
Email:	
RESPONSIBLE PARTY INFORMATION	Same as Patient □
Name:	Spouse □ Parent □
Address:	
Street Apt.	
	Date of Birth:
City State Zip	
Phone:	
Home Cellular	
EMPLOYMENT INFORMATION	Occupation:
Employer:	Length of Employment:

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

Education / Last grade completed

Family History	Name	Age	Mental Health History
PARENT			
PARENT			
SIBLINGS			
CHILDREN			

Marital History including previous marriages

Name of Spouse	Age	Marriage/Divorce Dates	Condition of Marriage

Psychiatric & Medical History

List prior counseling, psych hospitalizations, substance, eating disorders treatments and dates:
List chronic medical conditions, year diagnosed and treating doctor:
List all medications taken on a daily basis, include PRN:

- 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 $175.00 and fee for subsequent sessions $150.00. The Missed Session Fee is $85.00, 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 of $___________ 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. __________ (Initial here)

- 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 or text, regardless of reason, is charged the Missed Session Fee. Insurance cannot be billed when the insured is not present. __________ (Initial here)

- I understand that if I fail to attend two consecutive sessions without 24-hours' notice or consistently cancel appointments, the behavior could result in termination of the therapist's psychotherapy service since missed sessions can be disruptive to the therapeutic relationship. If there is no contact from you in 6 months your case will be closed. __________ (Initial here)

- This clinician does not complete forms for disability, FMLA, or support animal documentation. An $85.00 fee is assessed for each letter or other forms client requests clinician to complete. __________ (Initial here)

- I understand that in the event disclosure of my records or therapist testimony is subpoenaed, I will be responsible for and shall pay the cost involved in producing those records at $2.00 per page ($50.00 minimum – payable in advance). The therapist will be paid $350.00 per hour (minimum 3 hours – payable in advance, 7 days prior to the hearing) for the time involved in preparing for, travel time, and giving testimony. ___________ (Initial here)

- 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 crisis or psychiatric emergency please call 9-1-1. ___________ (Initial here)

- I give my permission for the therapist to call and leave messages at my home or cell. 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. This clinician will only respond to texts regarding appointments and will not respond to any other social media contact. __________ (Initial here)

- I consent to participate in telehealth with Dorothy J. Phillips, LCSW, as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology-assisted media between a practitioner and client who are located in two different locations. __________ (Initial here)

- I understand the following regarding telehealth:

  - I need to know your location at the beginning of each session in case of an emergency. __________ (Initial here)

  - I understand there are risks, benefits and consequences associated with telehealth including but not limited to disruption of transmission by technology failures, interruption and or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. __________ (Initial here)

  - I understand there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to a anyone without written authorization, except where the disclosure is permitted and/or required by law. __________ (Initial here)

- I understand I am 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. __________ (Initial here)

- 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. ________ (Initial here)

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

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. 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. 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. __________ (Initial here)

Client Signature	Date

Dorothy J. Phillips, LCSW

Cell: 214-642-3618 FAX: 972-931-2317

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CPR Part 2 or Mental Health, Chapter 51.38, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it. This release will automatically expire in one year.

I, ________________________________ hereby authorize Dorothy J. Phillips LCSW to contact:

____

Name of person and/or organization, office phone and fax numbers

____

Address

The following written and verbal information:

______ Progress Notes ______ A Summary of All Services ______ Social History
______ Medications ______ Diagnosis Only ______ Other:

____

The purpose for the disclosure of this information is to:

______ Assist in evaluation and treatment planning
______ Facilitate family involvement in treatment
______ Coordinate treatment services between providers
______ Other ____

This release expires upon the fulfillment of the purpose for which the Release was enacted. I further acknowledge that the information to be released was fully explained to me and this consent was given of my own free will. I understand that information used or disclosed pursuant to the Authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Texas law may protect such information.

____

Client Signature Date