(For parents to complete)

TAFT COUNSELING CENTER

The information below is to help us understand you and your child's situation and to enable us to help you. Please fill out these forms as completely as you can. All information given is strictly confidential and would not be released without your written permission.

PARENTS or GUARDIAN PERSONAL INFORMATION

DATE_____

Parent Name **May we leave message**

_____ Home Phone _____ ☐ YES ☐NO

Last First Middle

Cell Phone_____ ☐ YES ☐NO

_____Work Phone _____ ☐ YES ☐NO

Address City Zip Code

Male ____ Female_____ Age_____ Date of Birth _____ Social Security #_____

Race_____Ethnicity_____

Occupation _____Employer's Name___ _____

INFORMATION ON MARRIAGE (check one):Single (never married)__Married___Divorced___Widowed___

Present Marriage or Latest Marriage:

Name of Spouse_____Occupation_____ Age____
Address (if different)_____Phone_____
Date of Marriage_____ Ages when married: Husband____Wife____Time known before marriage____

Children of this marriage:

Name	Age	Sex	Now living with you
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

Legal Action Taken: Divorce filed by you_____Spouse_____Date filed_____
Living at Home? (yes/no) You_____Spouse_____If marriage was terminated, when?_____

Previous Marriage:

Name of Spouse_____Occupation_____ Age____
Date of Marriage_____ Ages when married: Husband____Wife____Time known before marriage____

Children of this marriage:

Name	Age	Sex	Now living with you
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

Legal Action Taken: Divorce filed by you_____Spouse_____Date filed_____

Children's Symptom Checklist

Check the items that describe or relate to the concerns you have:

_____Sleep disturbance	_____Appetite change	_____Anger
_____Withdrawal from others	_____Depressed mood	_____Self injury
_____Anxious or fearful	_____Hyperactive	_____Suicidal thoughts or behaviors
_____Defiant	_____Oppositional	_____Nightmares
_____Clinging behaviors	_____Sexual activity	_____Follow through on tasks
_____Plays well with others	_____Unreasonable fears	_____Trauma history
_____Substance abuse	_____Irritability	_____Easily distracted
_____Difficulty with daily routine	_____Aggression toward self or others	

_____Other information that will help us to help your child_____

_____

_____

_____

_____

_____

_____

Previous counseling or psychotherapy? _____ When_____

Presently seeing another therapist? _____Who_____

Presently on medication? _____ Name of medication and dosage_____

For what condition? _____ Doctor prescribing medication? _____

COUNSELING INFORMATION AND CONSENT FORM

Thank you for selecting our Center. We are proud of our staff and our history of service to the community. This consent form explains some information about the counseling experience. The counselor will review this information with you during your first session. We think it is important that you read or hear and understand this information. You will be asked to acknowledge that you understand the Center's policies and your treatment. To assure a full understanding, you are invited to discuss any item or question with the therapist.

DUTY TO WARN:

The Center is committed to the confidentiality and privileged communication of all clients. There are, however, several exceptions. According to Texas Law, any evidence of child or elderly abuse must be reported. Also, if an individual intends to take harmful, dangerous or criminal action against another human being, or against himself or herself, it is the therapist's duty at this Center to report such action or intent.

Signature_____

(Required as a Duty to Warn Acknowledgement)

In An Emergency Please Notify:

Name_____ Relationship_____ Cell Phone_____

Address_____City_____State_____Zip Code_____

Name_____ Relationship_____ Cell Phone_____

Address_____City_____State_____Zip Code_____

FEES AND APPOINTMENTS:

FEES: Our regular fee is $120.00 for a 30 – 45 minute session and $60.00 for a 60-90 minute group session. If you do not have insurance, a sliding scale based on your family income may be available. Please feel free to discuss this with the business office.

INSURANCE: Some policies may cover, please check your policy or call your insurance company to determine the exact coverage, if any. Note too, if **POLICY DEDUCTIBLE HAS NOT BEEN SATISFIED YOU ARE RESPONSIBLE FOR PAYING THE ALLOWED AMOUNT.** We will assist you with your insurance filing; meanwhile you are expected to pay the quoted fee at the time of service. If you seek third party reimbursement, you may be waiving the confidentiality of your sessions and any records of those sessions with your insurance company.

My signature affirms that I have read or heard the information above and that it was presented to me in a clear, non-technical language. This information is understood by me and enables me to make an informed voluntary consent to this treatment.

_____ _____

Date Client (or guardian's) Signature

_____ _____

Date Therapist's Signature

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, CLIENT BILL OF RIGHTS AND CONSENT

You may refuse to sign this acknowledgement. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

Adult or Legal Guardian/Representative Signature:

_____ _____ ***Date:*** _____

Please print your name ***Please sign your name***

Minor Information:

_____ _____ ***Date:*** _____

Relationship to Client ***Client name***

Taft Counseling Center, Inc.
4722 Taft Blvd., Suite 2
Wichita Falls, TX 76308
(940) 691-1899

SIGNATURE ON FILE
RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

1.) I hereby authorize my insurance benefits/ Employee Assistance Program (EAP) to be paid directly to Taft Counseling Center Inc. (TCC). I realize that I am responsible to pay non-covered services (all co-pays, co-insurances and deductibles) at the time of service. I hereby authorize the release of required information to the *insurance carriers and their representatives* for the processing of claim submission. I authorize this form to be copied and used on all my insurance submissions including electronic filing (signature on file). I authorize my therapist/TCC to act as my agent in helping obtain payment from my insurance carriers. *Initial*____________

2.) If an appointment is missed (NCA) or canceled with less than 24 hours' notice (LCA), I understand that I will be charged a $25.00 fee <u>not billable to insurance</u>. I understand that there is a $25.00 fee <u>not billable to insurance</u> for additional paperwork that is payable at the time of request. I understand if I am using Private Pay that I am responsible for the fee quoted at the time of service. I understand that charges can result because I have not provided current and valid insurance policy information. *Initial*___________

3.) Due to any type of incapacitation of your counselor your records will be retained by TCC *Initial*__________

4.) <u>I AUTHORIZE THE RELEASE OF VERBAL AND /OR WRITTEN INFORMATION TO:</u>

Texas Department of Family & Protective Services (Child Protective Services) Initial__________

My probation/parole officer ___________________________ TDCJ ____

My DARS caseworker ___________________________ Other ____

Other Parent or Guardian____

I authorize release of my Psychological Evaluation/Bariatric report to Dr. _____________________________as part of my pre/ post operation requirements.

I authorize the release of verbal &/or written release to Dr. _____________________________ regarding psychotropic medication or medication management

____

<u>Signature for Authorization of release</u>

♦♦

<u>SIGNATURE ON FILE</u>
For Electronic Filing

Name____Date______________________
(Please print)

Signature____ Date_________________________

TAFT COUNSELING CENTER, INC.
INSURANCE INFORMATION

If you have insurance and want the Center to file your insurance, you must complete all of the information below. **Any information, which is omitted, will delay in the filing of your insurance.**

Please be advised *that any benefits, which your insurance carrier quotes to Taft Counseling Center,* ***are not a guarantee*** *of payment of benefits. All insurance companies read a disclaimer before quoting benefits to any provider.* ***Your co-pay will be dependent on your diagnostic code and can be different from the original quote given to the business office****. Please read your Explanation of Benefits from your insurance company when you receive it, your responsibility will be shown.*

******Please initial acknowledging you have read the above disclaimer. __________******

♦♦

Primary Insurance:

Policyholder's complete name____

DOB____________ SSN______________________ Race________________ Ethnicity____________________

Your relationship to policyholder_____________________________

Policyholder's complete address____

Home Phone __________________ Cell Phone_________________ Work Phone _________________________

Name of Insurance __________________________________ Number to verify benefits_____________________

Subscriber / Sponsor ID _____________________________________ Group Number_______________________

Policyholder's Employer __________________________________Address________________________________

Patient's complete name____________________________ DOB______________ SS#______________________

Have you ever had same or similar illness, if so please give date____

What date did you first notice current symptoms? ____

Secondary Insurance: (*Tricare and Medicaid will be secondary to any other insurance*)

Policyholder's complete name____

DOB____________ SSN______________________ Race________________ Ethnicity____________________

Your relationship to policyholder_____________________________

Policyholder's complete address____

Home Phone __________________ Cell Phone_________________ Work Phone _________________________

Name of Insurance __________________________________ Number to verify benefits_____________________

Subscriber / Sponsor ID _____________________________________ Group Number_______________________

Policyholder's Employer __________________________________Address________________________________

Patient's complete name____________________________ DOB______________ SS#______________________

If you have a deductible, it has to be met before insurance benefits will be payable. The Center requires you to pay a portion of the fee even if you have insurance. When you terminate therapy if you have a refund due from overpayment, the business office will issue you a refund check.

____

Signature