TAFT COUNSELING CENTER

The information below is to help us understand you and your situation. Please fill out these forms completely. All information given is strictly confidential and will only be released with your written permission.

PERSONAL INFORMATION DATE_____

May we leave message

Name_____ 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 #_____

Marital Status (Circle one): Single (never married) Married Divorced Widowed

Race: _____ Ethnicity: _____

Employer's Name_____ Address_____

Occupation _____

Education (circle last year completed) School 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 5 6+

Other Training _____

Religion: Do you attend church now? _____Where? _____
Do you believe in God? _____

Military Service: _____ Combat Service? _____
Dates Branch of Service

Physician_____ Contact for Information? Yes_____ No_____

If referred – By Whom?
_____
Do we have your permission to notify your referring source of your appointment?
Yes____ No_____ Initials _____

Have you had previous counseling or psychotherapy? _____ When_____

Are you presently seeing another therapist? _____Who_____

Are you presently on medication? _____ Name of medication and dosage_____

For what condition? _____ Doctor prescribing medication? _____

INFORMATION ON FAMILY OF ORIGIN:

1. Who raised you? _____
2. Biological Parents:
   Father: Age_____ Deceased____ (Date of Death_____) Divorced___your age at the time_____
   Mother: Age_____ Deceased____ (Date of Death_____) Divorced___your age at the time_____
3. Adoptive Parents:
   Father: Age_____ Deceased____ (Date of Death_____) Divorced___your age at the time_____
   Mother: Age_____ Deceased____ (Date of Death_____) Divorced___your age at the time_____
5. Other Parents: Stepfather married your mother at your age of _____
   Stepmother married your father at your age of _____
   Describe any children who joined your family at these times: _____
   _____
6. Children of your Family of origin (Brothers and sisters - list by birth order, including self)

Name	Sex	Age Now	Deceased	Date of Birth
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____
_____	___	_____	___	_____

7. Have any other family members died? _____
8. What particular problems did you have as a child? _____
   _____

INFORMATION ON MARRIAGE:

Present Marriage or Latest Marriage:

Name of Spouse_____Occupation_____
Address (if different)_____Phone_____
Business Address_____Phone_____
Spouse's Age_____ Education (in years) _____ 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_____ If marriage was terminated, when?_____ Living at Home? (yes/no) You_____ Spouse_____

Previous Marriage:

Name of Spouse_____Occupation_____
Age when married: Husband____Wife____Date of Marriage_____Length of Marriage_____
Reason for Termination: _____
Divorce_____ Date of termination_____Legal Action Taken by: Self_____Spouse____
Children of this marriage:

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

INFORMATION ON HOUSEHOLD:

1. Who lives at your address?

Name	Age	Sex	Relationship?
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

2. Are there members of your family or household who have had a drinking or drug use problem?
Describe_____

CURRENT NEEDS AND CONCERNS:

State in your own words the concerns you bring with you to counseling_____

_____

_____

_____

What are your goals for counseling?_____

_____

How do you envision your beliefs, faith, or spirituality as part of your therapy?

_____

What are your faith concerns? _____

_____

Check the items that describe or relate to the concerns listed above:

_____Bereavement (grief)
_____Depression
_____Weight gain/loss
_____Anxiety
_____Nervousness
_____Relationship with Superiors
_____Marriage Problems
_____Sexual Concerns
_____Infidelity of Self
_____Infidelity of Spouse
_____Physical Abuse
_____Sexual Abuse
_____Emotional Abuse
_____Verbal Abuse
_____Illness of Self
_____Illness of Relative/Friend
_____Alcohol
_____Drugs
_____Self Doubt
_____Vocational Direction
_____Communication Problems
_____Intense Anger
_____Insecurity
_____Guilt
_____Suicidal Feelings/Thought
_____Sleeplessness
_____Troubled Dreams
_____Relationship with Parents
_____Relationship with Children
_____Relationship with Co-Workers
_____Religious Doubts/Fears
_____Anger with God
_____Loss of Faith in God
_____Loss of Faith in Others
_____Loss of Faith in Self
_____Loss of Self-Respect
_____Loss of Meaning
_____Loss of Hope
_____Loss of Love
_____Other

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

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 electric filing. 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>

DFPS/My CPS caseworker _____________________________ My probation officer ___________________________________

My DARS caseworker ___________________________ Other ____

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 ON FILE</u>

Name____Date_______________________
(Please print)

Signature____ Date________________________

♦♦

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 <u>may not be allowed</u> 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.

<u>Adult or Legal Guardian/Representative Signature:</u>

___________________________________ ___________________________________ ***Date:*** _________________

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

<u>Minor Information:</u>

__________________________________ __________________________________ ***Date:*** _________________

Relationship to Client ***Client name***

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