

**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 \_\_\_\_\_

**Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **May we leave message**  NO  
 Last First Middle  
**Cell Phone** \_\_\_\_\_  NO  
**Work Phone** \_\_\_\_\_  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 \_\_\_\_\_

If referred – By Whom?  
\_\_\_\_\_

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: You \_\_\_\_\_ Spouse \_\_\_\_\_ 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: You \_\_\_\_\_ Spouse \_\_\_\_\_ 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:**

<input type="checkbox"/> Bereavement (grief)	<input type="checkbox"/> Communication Problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Intense Anger
<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Insecurity
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Guilt
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Suicidal Feelings/Thought
<input type="checkbox"/> Relationship with Superiors	<input type="checkbox"/> Sleeplessness
<input type="checkbox"/> Marriage Problems	<input type="checkbox"/> Troubled Dreams
<input type="checkbox"/> Sexual Concerns	<input type="checkbox"/> Relationship with Parents
<input type="checkbox"/> Infidelity of Self	<input type="checkbox"/> Relationship with Children
<input type="checkbox"/> Infidelity of Spouse	<input type="checkbox"/> Relationship with Co-Workers
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Religious Doubts/Fears
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Anger with God
<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Loss of Faith in God
<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/> Loss of Faith in Others
<input type="checkbox"/> Illness of Self	<input type="checkbox"/> Loss of Faith in Self
<input type="checkbox"/> Illness of Relative/Friend	<input type="checkbox"/> Loss of Self-Respect
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Loss of Meaning
<input type="checkbox"/> Drugs	<input type="checkbox"/> Loss of Hope
<input type="checkbox"/> Self Doubt	<input type="checkbox"/> Loss of Love
<input type="checkbox"/> Vocational Direction	<input type="checkbox"/> 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.

**Required as a Duty to Warn Acknowledgement**

**Signature** \_\_\_\_\_

**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 \$130.00 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.

**Court:** You may request or your attorney may issue a subpoena for a counselor to appear in court. In any case where court is involved (other than a CPS court issued subpoena), you must be aware that a cash only fee of \$130.00 per clinical hour of (45 minutes) will be charged. This amount is charged for preparation time, travel time, and actual time spent in court, whether or not actual testimony is given. This compensation, in accordance to the Texas Rules of Civil Procedure, shall be made by the party retaining the services of Taft. Furthermore, payment for five (5) clinical hours shall be made to Taft on or before the date of the appearance as a reinter, and following the conclusion of the court proceedings, funds will be refunded or additional fees billed based on the actual time spent in court activates, the total fee charges is the client’s responsibility to pay upon receipt of statement.

**INSURANCE:** Some policies may cover, please check your policy or call your insurance company to determine the exact coverage, if any. 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.

*My signature confirms 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.*

\_\_\_\_\_  
Client (or guardian’s) 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 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.**

\_\_\_\_\_  
Please print your name \_\_\_\_\_  
Please sign your name \_\_\_\_\_  
Date

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). If an error occurs with the EAP company, I hereby authorize TCC to bill the insurance on file. 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. 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. If you have a deductible, it has to be met before insurance benefits will be payable. When you terminate therapy if you have a refund due from overpayment, the business office will issue you a refund check. 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.

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 not billable to insurance. I understand that there is a \$25.00 fee not billable to insurance for additional paperwork, forms or documentation completed by the counselor 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.

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

**SIGNATURE ON FILE  
For Electronic Filing**

Name \_\_\_\_\_ Date \_\_\_\_\_  
(Please print)

Signature \_\_\_\_\_ Date \_\_\_\_\_



**I AUTHORIZE THE RELEASE OF VERBAL AND /OR WRITTEN INFORMATION TO:**

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

\_\_\_\_\_  
Signature for Authorization of release

**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.

**Primary Insurance:**

**Policyholder's Information:**

Policyholder' Full Name: \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code \_\_\_\_\_ Your relationship to policyholder \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Policyholder's Employer \_\_\_\_\_ Name of Insurance \_\_\_\_\_

Member / Sponsor ID \_\_\_\_\_ Group Number \_\_\_\_\_

**Patient Information:**

Patient's complete name \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

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 other insurance)**

**Policyholder's Information:**

Policyholder' Full Name: \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code \_\_\_\_\_ Your relationship to policyholder \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Policyholder's Employer \_\_\_\_\_ Name of Insurance \_\_\_\_\_

Member / Sponsor ID \_\_\_\_\_ Group Number \_\_\_\_\_

**Patient Information:**

Patient's complete name \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

