(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 _____ ☐NO
Last First Middle

Cell Phone _____ ☐NO

_____ Work Phone _____ ☐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: 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_____
Living at Home? (yes/no) Self_____Spouse_____If marriage was terminated, when?_____

Previous Marriage:
Name of Spouse_____Occupation_____ Age____
Date of Marriage_____ Ages when married: Self____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_____

Children's Symptom Checklist

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

☐ Sleep disturbance	☐ Self-injury	☐ Oppositional	☐ Trauma history
☐ Appetite change	☐ Anxious or fearful	☐ Nightmares	☐ Substance abuse
☐ Anger	☐ Hyperactive	☐ Clinging behaviors	☐ Easily distracted
☐ Withdrawal from others	☐ Suicidal thoughts or behaviors	☐ Sexual activity	☐ Difficulty with daily routine
☐ Depressed mood	☐ Defiant	☐ Follow through on tasks	☐ Aggression toward self or others
☐ Unreasonable fears	☐ Doesn't play well with others	☐ Irritability	

Previous counseling or psychotherapy? _____ When_____

Presently seeing another therapist? _____Who_____

Presently on medication? _____ Name of medication and dosage_____

For what condition? _____ Doctor prescribing medication? _____

Other information that will help us to help your child_____

_____

_____

_____

Which parent(s)/ legal guardian(s) has the legal authority to consent to treatment?

Please check box most appropriate:

☐Both Legal Parents/Guardians have authority to consent to treatment. I authorize the release of information to _____.
(other parent or guardian)

☐If the biological or legally adopted parents are currently separated or going through the divorce process, the parent presenting child for treatment will have to sign a release for the other parent or guardian before the child can be treated

☐Divorce, Custody or Legal Issues: There is an official certified divorce decree or a legal custody order that indicates that only one parent is legally permitted to determine and decide on mental health treatment of the child without the consent of the other parent.

☐The parent presenting child for treatment has no access to other parent due to the following reasons (death, in prison, missing, has left and made no contact, etc...) and therefore will acknowledge that they are the sole primary care taker of the child for mental health treatment and will bare all responsibility for such consent.

I affirm that I have the authority to make mental health care decisions for my child and am aware that all custodial parents and legal guardians have the authority to consent to treatment and obtain records. I have provided the clinic with a certified or legal copy of the divorce or custody decree that indicates that I have the authority to make any and all decisions in regards to my child's mental health treatment or I have signed a Release of Information to my child's other custodial parent or legal guardian. I acknowledge that the other parent or guardian may need to be notified if they have rights to mental health information and it is my responsibility to notify the other parent according to the legal case. I further acknowledge and agree that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreements, etc. I acknowledge that Taft Counseling Center is requesting any and all related documents for the benefit of my child and therefore release any liability to Taft Counseling Center, any of its providers, office staff, and/or affiliates resulting from a dispute to this authorization.

☐ I have provided a copy of the official custody agreement.

☐ I did not provide a copy of the official custody agreement and release information to _____
(other parent or guardian)

_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

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 $150.00 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 my 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 $150.00 per clinical hour of (45 minutes) will be charged. This amount is charged for perpetration 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.

Parent or Legal Guardian Signature:

_____ _____ _____

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

_____ _____ _____

Relationship to Client **Minor client's name** **Date**

TAFT COUNSELING CENTER, INC.

SIGNATURE ON FILE

RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

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. Humana Military referrals require release of information to the referring Military Treatment Facility.

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**_____

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: _____

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: _____

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_____