



930 N. Nolan River Rd  
Cleburne, TX 76033  
Phone: 817-666-3068

Patient Information: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone:(\_\_\_\_\_)\_\_\_\_\_ - \_\_\_\_\_ Other Phone:(\_\_\_\_\_)\_\_\_\_\_ - \_\_\_\_\_

May We Leave a Message [ ] YES [ ] NO May We Leave a Message [ ] YES [ ] NO

Patient Social Security # : \_\_\_\_\_ Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender: [ ] Male [ ] Female email address: \_\_\_\_\_

Marital Status: [ ] Married [ ] Single [ ] Divorced  
[ ] Separated [ ] Widowed [ ] NA (children)

Employment Status: [ ] Employed [ ] Student [ ] Unemployed

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured's Information:

If the insurance you are using is provided to you through a family member you must complete the following for us to bill the insurance on your behalf.

Insured's Name: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's place of employment: \_\_\_\_\_

If different from above:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone:(\_\_\_\_\_)\_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

In Case of Emergency, Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_ May we thank them: [ ] Yes [ ] No

Are you seeking counseling related to a court order or legal proceedings? [ ] Yes [ ] N



## Informed Consent for Receipt of Counseling Services (Adult)

This form is to document that I, \_\_\_\_\_ give voluntary permission and consent to receiving counseling services from Hope Restored Counseling Services.

\_\_\_\_\_ Purpose and Background:

The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of Texas to provide counseling and/ or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his credentials and expertise. While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Hope Restored Counseling. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

\_\_\_\_\_ Confidentiality:

I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to her/his own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

\_\_\_\_\_ HIPAA

I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of Hope Restored Counseling "Notice of Privacy Practices", that were effective of as their start of business in June, 2007. I acknowledge I was offered this policy statement on the date indicated by my signature below. If I feel I need immediate psychiatric admission to a hospital for stabilization, I understand that I may be referred to the nearest hospital emergency room.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.

I release and hold harmless Hope Restored Counseling and its staff and agents from any action or liability arising out of my participation in treatment.

\_\_\_\_\_  
Signature of client Date



## Consent To Bill Third Party Payer

### Use of Insurance:

As a part of receiving psychological services through Hope Restored Counseling Services, I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third party payer, i.e. medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will definitely mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and at times may constitute the release of treatment planning information.

### Charges for Services:

Court Related Fee \$500.00 (for first 4 hours or less, \$500 for next 4 hours or less)

Psychotherapy Session (45-50 min) \$90

Case Management (per 15 minute) \$ 35.00

Missed Appointment/ Late Cancellation \$ 50.00

### Payment:

I understand that payment is expected at time of service. If I wish to pay for services out of pocket, or for the purposes of making my co-payment, should I elect to use my insurance, I may make payments via cash, check, or card. I understand all checks returned unpaid will be subject to a \$25.00 service fee, and if they remain unpaid for more than three months, may be turned over to a collection agency for the purpose of recovering lost funds.

### Use of Insurance and Authorization for Treatment:

If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/ or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral or not following necessary guidelines set by my insurance company for accessing mental health benefits. I understand I will be charged \$50.00 for missed or cancelled appointments unless prior notification is given 24 hours prior to the time of the appointment, I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.

I, \_\_\_\_\_,

- wish to use my medical insurance to off-set the cost of treatment, and in so doing give Hope Restored Counseling Services permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my therapist any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.
- do not wish to use any medical insurance benefit to cover services I receive through Hope Restored Counseling Services. I understand that I am financially responsible for all expenses incurred for my treatment, and will make all payments at the time of service.

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Signature of Client/Responsible Party

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Date



## Missed Appointment Policy

I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a “No Show” and will subject to a \$50 fee per missed appointment. In addition, if I miss more than two appointments in an 8 week period, a subsequent appointment time cannot be guaranteed .

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Signature of client/Responsible Party

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Date



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

1. Why have you come to Hope Restored Counseling (Presenting issue for Client)?

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2. How long has this been an issue? \_\_\_\_\_

3. What have you tried to do to resolve this issue?

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4. What are your goals for counseling?

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5. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency/ use):

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6. Has any other member of your family (including extended family) been diagnosed or had significant problems with mental health issues and / or alcohol use or chemical dependency? Please explain:

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7. Who resides with you in your home?

Name and Relationship:

Age:

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8. Medical History:

Health (describe your general health as well as any chronic conditions including pain)

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9. Who is your primary care physician? \_\_\_\_\_

When was your last complete physical exam by an M.D.? \_\_\_\_\_

Are you currently under the care of an M.D. for any condition? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Please list all current medications including over-the-counter and prescription medications:

Name of Medication:	Dosage:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all prior medication for mental health issues, chemical dependency or alcohol use:

Name of Medication:	Dosage:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Please check any of the following that apply:

Significant weight gain/ loss in the last six months  Dieting

Food / drug allergies  Overeating or eating too little

Problems chewing or swallowing

If any box is checked, please explain:

\_\_\_\_\_  
\_\_\_\_\_

11. Do you have any functional limitations that affect your daily living (ex: physical impairments, problems with self care, speech, vision, or hearing)? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain: \_\_\_\_\_

12. Legal History:

Please place an "N" for none, "C" for currently experiencing, or "P" for experienced in the past.

DUI \_\_\_\_\_ Bankruptcy \_\_\_\_\_ Divorce \_\_\_\_\_

Unemployment \_\_\_\_\_ Domestic Violence \_\_\_\_\_ Custody Dispute \_\_\_\_\_

Disability Claim \_\_\_\_\_ Workman's Compensation \_\_\_\_\_

13. Financial Problems: \_\_\_\_\_

14. Educational Background (highest grade completed): \_\_\_\_\_

15. Employment History (Please describe current job briefly):

\_\_\_\_\_  
16. Military Service: \_\_\_\_\_

17. History of Abuse:

Please place an "N" for none, "C" for currently experiencing, or "P" for experienced in the past.

Verbal Abuse \_\_\_\_\_ Emotional Abuse \_\_\_\_\_ Childhood Abuse \_\_\_\_\_  
Physical Abuse \_\_\_\_\_ Spouse Abuse \_\_\_\_\_  
Sexual Abuse \_\_\_\_\_ Elder Abuse \_\_\_\_\_

18. Alcohol and Drug Use:

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how often? \_\_\_\_\_

When was the last time you had a drink? \_\_\_\_\_

How much did you drink at that time? \_\_\_\_\_

Do you have any history of using or abusing drugs/medications? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you currently abuse any drugs/medications? Yes \_\_\_\_\_ No \_\_\_\_\_

What substances have you used in the last 6 months? (check all that apply)

Marijuana/ "Pot"                       Cocaine                                       Inhalants/ "Huffing"  
 LSD/ "Ac id"                               Amphetamines/ "Speed"                       Other  
 Pain Killers                               Sedatives/ "Downers"                       None of Above

If "Other" is checked, explain below:

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Check any of the following that has occurred as a result of your drinking or drug use :

Arrest                       DUI                                       Family Problems  
 Public Intoxication                       Financial Problems                       Arguments  
 Work Problems                       Health Problems                       Relationship Problems

Do you use Nicotine? Yes  No  Amount? \_\_\_\_\_

Do you use Caffeine? Yes  No  Amount? \_\_\_\_\_

19. Sexual/ Affectionate History:

Are you satisfied with your sex life? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any concerns or question about your sexual orientation or experiences? (If so, please explain)

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20. Religious/Spiritual History:

Do you have an identified religious preference? \_\_\_\_\_

21. History of Harm to Self or Others:

Do you currently have any urges/ thoughts of hurting yourself? Yes \_\_\_\_\_ No \_\_\_\_\_

Any current urges/ thoughts of hurting another? Yes \_\_\_\_\_ No \_\_\_\_\_

Any history of hurting self or suicide attempt? Yes \_\_\_\_\_ No \_\_\_\_\_

Any history of physical aggression toward another? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes on any of these questions, please describe in the space below:

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