COMMUNITY COUNSELING CENTER

515 N. Penelope Street, Belton, TX 76513

254.933.3306

ADULT PERSONAL HISTORY

Date: ___________________

I. IDENTIFYING INFORMATION

A. Full Name: ____SSN: ____________________

B. Address ____Phone Number________________

City/State/Zip _____________________________________

Email Address____

C. Present Living Situation (with *whom*?): ____

D. Date of Birth __________________ Age: ________ Education Level: ____________

E. Information given by: ________________________________ Client __________________

Other (*specify*) ___________________________________

F. Insurance Information: Carrier____________________Member #______________________

Group #___________________Primary's Name_________________________DOB__________

SS#____________________Employer______________________Relationship to primary_____

II. PRESENTING PROBLEM:

A. For what problems are you seeking professional assistance: _________________________

____

____

B. Give a brief account of the history and development of your complaint(s) from the start____

____

____

____

present: ____

____

____

____

III. MENTAL HEALTH HISTORY:

Have you ever received mental health and/or substance abuse treatment?

Yes______ NO___

Yes____ No_____

_____Yes ____ No

Where? ______________________________ When? __________________

IV. CURRENT/PAST HEALTH STATUS:

List any serious illnesses, injuries, and hospitalizations with approximate dates:

____

____

____

Childhood diseases: ____

____

____

List allergies including drug or prescription medication: ________________________________

____

Have you experienced problems with your appetite recently? If Yes, explain: _________

____

____

Do you experience dreams and/or nightmares? Explain: ___________________________

____

List medication you have taken (include dosage) within the last 6 months:

__________________ **Dosage** ______ **Prescribed by:** ______________________ **When?** _______

__________________ **Dosage** ______ **Prescribed by:** ______________________ **When?** _______

__________________ **Dosage** ______ **Prescribed by:** ______________________ **When?** _______

Do you use alcohol? ______ **Type** ________________ **Amount**________ **Frequency** __________

Do you use drugs? _______ **Type** ________________ **Amount**________ **Frequency**__________

Over-the-Counter? ______ **Type** ________________ **Amount**________ **Frequency**__________

Date and Place of Most Current Physical Exam: ______________________________________

Name of Physician Performing Exam: ____

Significant Findings: ____

Current Family Physician: ____

V. SOCIAL HISTORY

Place of Birth _______________________________ **Military Status:** __________________

Father's Name _____________________________ **Age** ___ **Occupation:** _______________

Mother's Name _____________________________ **Age** ___ **Occupation:** _______________

Names and ages of:

Brothers: ____

Sisters: ____

Briefly Describe Your Childhood (*use the back of the sheet, if necessary*):

____

____

____

Schools Attended (where and when): ____

____

List Hobbies, Interests, and Leisure Time Activities: _______________________________

____

VI. RELIGIOUS BACKGROUND AND PRESENT PREFERENCE:

____

VIII. MARITAL HISTORY: List all Marriages, Dates(s), Names of Spouse(s), Dates of Divorce(s), and Names and Ages of all Children: ____

____

____

IX. LEGAL HISTORY

A. Have you ever been incarcerated? ____YES ___NO If Yes, where: _________________

Dates ___________________________ **What Charges?** ______________________________

B. Are you currently on parole/probation? ____Yes ____No If Yes, please elaborate:

____

____

X. PERSONALITY SELF-EVALUATION*: (If the client is a child and is under the age of twelve, or if he/she feels uncomfortable with the remaining questions, please leave this portion blank).*

A. How well do you get along with people you know? ______________________________

B. How well do you express your feelings? ______________________________________

C. What do you do when frustrated or angry? _____________________________________

D. List any strong fears: ____

E. List main sources of stress: ____

F. How do you cope with stress? ____

G. What has been your most distressful experience? ______________________________

H. List your goals in life:

1. ____

2. ____

3. ____

Who referred you to the clinic?

____

What do you hope to gain from our services?

____

____

Further comments you would like to make, please place them on the back of this sheet. Thank you.

Person to contact in case of emergency:

____ ___________________ (_____) _____________

PRINT Name Relationship to client Phone

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Belton, Texas 76513
254.933.3306

POLICIES AND COUNSELING AGREEMENT

Thank you for selecting Community Counseling Center. Please carefully read the information provided below. Before you begin therapy, it is important that you fully understand your rights and responsibilities as a client of the Community Counseling Center.

YOUR RIGHTS AS A CLIENT

You have the right to ask questions about therapeutic procedures or methods used during your therapy.

You have the right to end therapy at any time without any legal or financial obligations other than those already incurred.

You have the right to select a different therapist. If you wish to continue therapy with a different therapist, you will be provided with the names of other qualified professionals whose services you may prefer.

One of your most important rights involves confidentiality. All therapeutic communications, records, and contacts with professional and support staff will be held in strict confidence. Information may be released, in accordance with state law, only when:

(1) The client signs a written release of information indicating informed consent
(2) The client expresses serious intent to harm himself/herself or someone else
(3) There is evidence or reasonable suspicion of abuse against a minor child, elder person (65 years or older), or dependent adult
(4) A subpoena or other court order is received directing the disclosure of information

THE THERAPEUTIC PROCESS

A major benefit of therapy is resolving the concerns that brought you to therapy. Another benefit is the ability to better handle or manage marital, family and other interpersonal relationships. Many times you will have a better understanding of personal goals and values which may lead to greater maturity and happiness as an individual.

In working to achieve these potential benefits, your therapy may involve a firm effort on your part to change. These changes may cause significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings such as fear, anger, depression and frustration. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not have originally been intended.

WORK AGREEMENT

It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in his or her life. Client gain is most important in professional counseling. Suspension, termination, or referral shall be discussed between the

counselor and client for a pattern of behavior that reveals disinterest or lack of commitment to counseling or for any unresolved conflict between counselor and client.

FEE AND SERVICE AGREEMENT

All fees are due at the time that services are provided. Professional fees are as follows:

Initial (Diagnostic) Session.......... $210.00
Subsequent 60 Minute Sessions………. $165.00

A **CASH DISCOUNT** WILL BE OFFERED TO ALL CLIENTS PAYING BY CASH OR CHECK. **THE Initial (Diagnostic) Session WILL BE REDUCED to $165.00 and the 60-minute Session WILL BE REDUCED TO $110.00**. If for some reason a client is not able to pay the day the service is rendered, the cash discount will still apply if the session fee is paid within seven (7) days of the session date.

Please also be aware that professional fees will be prorated for sessions that exceed 50 minutes. Please let your therapist know if additional charges resulting from longer sessions will be a problem. If you are using insurance, sessions that exceed 50 minutes are not covered under most plans.

There will be a fee for telephone consultation or sessions (15 minutes or more) based on the above-mentioned rates. You will be mailed a statement at the end of the business day that the telephone session occurred.

We take limited insurance at this time. If we are not in-network with your Insurance Provider, we will give you the information you need to file the insurance yourself.

If insurance(s) will be filed:

With my initials, I acknowledge that:

____ I hereby authorize Community Counseling Center to furnish information to my insurance carrier(s) concerning my illness and/or treatment.

____ I authorize payment of medical benefits to be paid directly to the Community Counseling Center and/or my counselor.

____ I understand that if I cancel an appointment **later than the 24-hour** cancellation period, or if I **miss the appointment with no cancellation notice**, I acknowledge the fee for the session will be billed to my account, and not to my insurance company in the amount of **$50**.

____ I understand that even though insurance claims may be filed, I am still directly responsible for payment of this account if the claims are not paid by the insurance company.

Signature: ____ Date: ___________________

We, the undersigned therapist and client(s), have read, discussed together, and fully understand this agreement and these policies. We agree to honor these policies.

Client Signature: _____________________________________Date: _________________

Therapist Signature: __________________________________ Date: ________________

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***** POLICY ON MISSED APPOINTMENTS *****

Therapy is by *APPOINTMENT ONLY*. The following charges will apply to missed or canceled appointments:

Appointments canceled, with **24 hours'** notice .... no charge
OR
Appointments canceled, with **less** than **24 hours'** notice; or not kept, with no notice given:
1st time ....1/2 session fee
2nd time ....full session fee

Missed or late canceled appointment charges will appear on your monthly statements or be brought to your attention by the office manager. Payment is due upon the receipt of a statement or the notification by the office manager.

WITH MY INITIALS, I ACKNOWLEDGE THAT:

____ I have read and do understand the Community Counseling Center's policy on missed appointments.

____ I understand that payment is expected as services are rendered unless prior financial arrangements have been made with the office manager.

____ I also understand should my account become 90 days past due, this information may be turned over to a collection agency.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT:

I understand that under the Health Insurance Portability Accountability Act (HIPAA) of 1996, I have certain rights to privacy in regard to my protected health information (PHI). I have been given the opportunity to review a copy of the Notice of Privacy Practices for the **Community Counseling Center.**

I understand that the **Community Counseling Center** reserves the right to change the terms of its Notice of Privacy Practices from time to time. I understand the **Community Counseling Center** will provide a current Notice of Privacy Practices upon request.

If signed by someone for a minor or incapacitated person indicate below the relationship of the person signing to the client.

_______Parent _____Guardian Other: ____________________

Signature: __________________________________ Date: ________________________

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THE TEXAS FAMILY CODE

THE TEXAS FAMILY CODE, SECTION 34.01,
PROVIDES THAT "ANY PERSON HAVING CAUSE TO BELIEVE THAT ANY CHILD'S PHYSICAL OR MENTAL HEALTH OR WELFARE HAS BEEN OR MAY BE ADVERSELY AFFECTED BY ABUSE OR NEGLECT SHALL REPORT IN ACCORDANCE WITH SECTION 34.02 OF THIS CODE"

IT IS OUR POLICY TO INFORM ANY PARENT THAT WE WILL ADHERE STRICTLY TO THE INTENT AND THE LETTER OF THIS STATUTE. IT IS NOT ONLY IN THE BEST INTEREST OF THE CHILD AND THE FAMILY, BUT WE ARE CRIMINALLY LIABLE IF WE DO NOT. THIS INCLUDES BUT IS NOT LIMITED TO, STRIKING OR HITTING A CHILD OR PUNISHING TO THE POINT OF LEAVING BRUISES.

I UNDERSTAND SECTION 34.01 OF THE TEXAS
FAMILY CODE AND THE REPORTING REQUIREMENTS

____
SIGNATURE

____
DATE

Patient | Library Links | Appointment Reminders

If you want to send appointment reminders by email,
PLEASE READ THE FOLLOWING TO THE CONSUMER

We can send you an appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your service provider name. We will not encrypt the messages. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, I need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

By checking the box below that enables E-mail reminders and entering an E-Mail address, you acknowledge that you have received consent from the patient.

☐ Enable E-mail Reminders for this patient

Send reminder [2] days prior to their next appointment

Recipient E-mail: [ ]