P.F. Dover Counseling and Hypnosis, P.L.L.C.

300 Trophy Club Dr.
Trophy Club, TX 76262

DEMOGRAPHIC INFORMATION

DATE: _____

Name(s): _____ Referred By: _____

Date(s) of Birth: _____ Age(s): _____ Gender: M F

Social Security #: _____ Driver's License #/State: _____

Employer: _____ Position_____

Home Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

How would you like to receive appointment reminders? (Circle one) Text Email

Medical/Psychiatric Diagnoses: _____

Current Medications: _____

_____

Medical concerns: _____

**If you are filing insurance claims for personal reimbursement and would like to obtain receipts/superbills:

Receipt/Superbill needed: _____ Yes _____ No

Name of Insurance Company: _____

Phone number of Insurance Company (See back of Insurance Card – Mental Health): _____

Full Name of Person that is Insured: _____

Date of Birth for Person that is Insured: _____

Phone Number of Person Insured: _____

Employer for the Person Insured: _____

Insurance ID#: _____

Group # for Insurance (If applicable): _____

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Policies & Payment Information:

APPOINTMENTS:

Appearing to your sessions on time and consistently is an important part of the therapeutic process. Appointment times are available for day or evening times. Individual sessions are for the standard 45-50 minutes. Group sessions are for 1 hour and 20 minutes. If a client chooses to remain after the session time, a charge of $25 will be added. Session times are reserved solely for you each week. Therefore: **(Please initial each blank)**

_____ A 24 hour **business** day notice is requested for cancelled sessions. If you cancel your appointment time in less than 24 **business** hours, you will be charged the full fee, as the session time is reserved for you and another client cannot be scheduled by then. Weekend hour cancellations **will be** charged, as your time cannot be filled with another client.

_____ If you fail to cancel or you "no show," you will be charged for the full fee since we save that time for you. *NOTE:* Insurance does not reimburse for cancelled appointments. You are responsible for fees incurred.

_____ After two missed appointments, your services may be terminated and your time slot will be given to another client.

_____ 15 minutes is the standard time for therapists to wait for clients to arrive. If you are more than 15 minutes late, please call me, as your session will be considered cancelled.

_____ As emergencies are unpredictable, I may run late depending upon the clinical needs of the session before you. This is regrettable and I will make every effort to prevent this from occurring. Please note that you will receive your full session time once we begin.

_____ Probation/Parole clients will be terminated unsuccessfully following two missed appointments. I am obligated to notify your probation/parole officer within 24 hours following each failure to show. Balances are required to be paid to avoid collections and charges for Theft of Services.

FEES:

Individual/family sessions are the standard rate of $150 for Scott Smith per hour, although a sliding scale is available to those who qualify. Cash, credit cards, and checks are accepted. The standard session length is 45-50 minutes; doubles are offered if desired and scheduling is available. Group rates are $45 per person. If on probation/parole, or managed care, standard contract rates apply. (Please initial each blank that applies):

_____ Full payment is due at the time services are rendered. If your therapist accepts in-network benefits, you will be only responsible for the contract rate.

_____ Cash, checks, credit cards, and money orders are accepted. There is a $30 fee for returned checks and cash is required thereafter. Returned checks are subject to collections and prosecution by law if not rectified.

_____ A credit card may be kept on file for your convenience (See attached credit card authorization form). Due to increasing credit card transaction fees to merchants, **there will be an additional fee of 4% of the amount paid**.

_____ Balances at the end of the month will charge a $30 fee; sessions may be suspended until the balance is paid in full.

_____ Records Request: There is a $1.00 fee per page for hard copy records request. Electronic records sent are no charge. Records will not be released if there is a balance on the account, including disability records requests.

_____ You are responsible for verifying your copayment amount, visit maximum, establishing and maintaining any authorizations required, and for filing your own claims for reimbursement. If we are in network, in network rates are accepted and are expected at the time of services rendered. We will be happy to provide any information you need to file your claim forms. We do not coordinate care, case consult, or give peer-to-peer reviews with insurance companies. *NOTE: Insurance companies do not reimburse for no shows.*

_____ A $25 fee is charged for forms or letters written on your behalf or request. Please allow one week for the forms/letter to be completed. (This does not include work/school absence excuses).

_____ A $25 fee is charged for telephone calls exceeding 10 minutes. Although phone sessions are not conducted, standard session rates apply for phone calls lasting 30 minutes or longer.

_____ **NO sessions or clinical information/discussions beyond rescheduling appointments will occur via text or email, as this needs to be contained and privacy protected in a clinical office setting.**

COURT:

If I am required to testify on your case, I require a proper service of subpoena to appear in court. Fax or email subpoenas are not accepted. Due to canceling all appointments prior to the court date, a non-refundable retainer fee is required to cover any lost income whether I am subpoenaed or requested to appear by your attorney **OR** by opposing counsel on your case.
(Please initial the blank):

_____ P.F. Counseling and Hypnosis, PLLC, does not conduct child custody evaluations or conduct child therapy for court purposes.

_____ A non-refundable retainer fee of $2000 (one full day plus preparation and travel time) of scheduled court attendance will be expected to be paid in full prior to court testimony as I will clear my schedule to comply - regardless of which side of the counsel I am required to testify for. For holiday appearances, the fee is $3000 a day. Additional fees may be incurred for additional hours in court until I am released by the judge whether or not I testify. If I am required to appear yet do not testify or am released early, the fee remains, as my schedule was cleared to accommodate.

_____ If you believe court appearance will be needed or potentially needed, an active credit card on file is required to recoup court costs and lost wages due to my required attendance.

_____ The charge will apply and be charged to you whether I am subpoenaed/requested to appear by either side of counsel.

ELECTRONIC COMMUNICATIONS

_____ Due to the sensitive nature of clinical and protected healthcare information/identification, your therapist will not discuss ANY clinical information via text or email beyond scheduling issues. Note that anything you write in text or email is considered part of your medical record and subject to the limitations of confidentiality (see Confidentiality Form). Please speak with your therapist directly regarding all clinical matters.

DEATH OR INCAPACITY OF THE THERAPIST:

_____ In the unfortunate event that your therapist becomes unable to continue to see you due to disability or death, by your signature below you are giving permission to the office coordinator and another licensed therapist to briefly review your file for the purpose of notifying you and possibly transferring you to another appropriate therapist. If this is unacceptable for any reason, notify the office coordinator or therapist before signing this document.

_____ Also, in the unfortunate event of your death, what becomes of your file may become an issue. It is possible that several people will want us to release information from it or even turn it over to them. It is in your best interest, as well as that of your family, and the professionals within this office, for you to tell us in advance to whom you **would** permit us to release information, **without** having a court order. You can choose to not give permission to anyone but if you want to permit one or more people, please list them on the following lines by full name and relationship, i.e. spouse, grown son/daughter, sibling, etc.

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

_____ I decline designating the releasing of my information to any party at this time.
(initials)

Agreement for Payment:
I have been informed of the fees and payment policies and I agree to the terms and conditions aforementioned.

Client/Parent Signature: _____ Date: _____

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PRE-AUTHORIZED CREDIT CARD FORM

We keep a credit card on file for your convenience. Please provide the following information:

I authorize P.F. Dover Counseling and Hypnosis, PLLC, to keep my signature on file and to charge my VISA/MASTERCARD (AmEx not accepted) account for the following: **(Initial all blank(s)**

_____ This visit only (agreed upon copay, coinsurance, or private pay)

_____ All visits this year (agreed upon copay, coinsurance, or private pay). Every visit will be charged to my credit card unless I stipulate otherwise.

_____ Balance of Charges not paid by insurance after 90 days.

_____ No Show/Late Cancellation charge (Full fee or agreed upon sliding scale amount via financial agreement form)

_____ One-time payment of $_____

_____ I understand that due to increasing credit card merchant fees, an additional transaction fee of 4% will be added.

I assign my insurance benefits to the practice listed above. I understand that this form is valid for one year unless I cancel the authorization.

_____
Client Name

_____ Card Type: Visa / MasterCard
Cardholder Name (AmEx not accepted)

_____
Credit Card Account Number 3-Digit Security Code Expiration Date

_____
Credit Card Holder's Address (****Required****) State Zip

_____
Client Signature Date

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CLIENT RIGHTS & RESPONSIBILITIES

Client Rights:
The therapeutic relationship benefits by having clearly defined rights and responsibilities held by each person. As a client, your well-being is of utmost importance. However, there are certain legal limitations to those rights that you should be aware of. Likewise, a therapist has corresponding responsibilities to you. *(See HIPAA Notice, Confidentiality Form)*

Parent Rights of a Minor:
Parents have a right to receive progress reports on their child's counseling. However, personal information shared by a child during an individual session will be kept confidential unless it involves imminent danger to the child or someone else. Young people will not confide in a counselor if they believe that personal information will be revealed to their parents; maintaining their trust is a priority. If there are situations that you may wish to know about yet may not be in the best interest of your child's treatment for your therapist share with you, your therapist's goal will be to encourage your child to reveal this information on his or her own. Regardless, your therapist will discuss and agree upon what situations warrant the sharing of information in the best effort to keep parents informed and active in the child's care.

Therapist's Therapeutic Approach:
Your therapist will use a variety of techniques in therapy, tailoring treatment to your needs. If a specific technique is proposed that may have special risks attached, the therapist will inform you of that, and discuss with you the risks and benefits of what they are suggesting. Your therapist may suggest that you consult with a physician regarding physical complaints, and may suggest you get involved in a therapy or support group as part of your treatment. You as the client have the right to refuse anything suggested without being penalized in any way. Your therapist will not engage in a social relationship with you outside of the therapy milieu while therapy is in place or for a minimum of two years following treatment termination. Your therapist will never engage in a sexual relationship with you either during therapy or after termination. Such relationships are unethical and illegal. Rules and codes may very depending on the license of the therapist, you may ask for a copy of the board rules from your therapist or access them online at any time. Therapy has potentially emotional risks, as it approaches feelings or thoughts that you have tried not to think about for a long time that may be painful. Making changes in your beliefs or behaviors can be frightening, and sometimes disruptive to the relationships and lifestyle that you currently have. a relationship with the therapist may be a source of strong feelings. Most people who take these risks, buying that therapy is helpful, and your therapist will do what they can to help you minimize the risks and maximize positive outcomes. Thorough explanations, procedures, risks, theory basis, and expectations to specialized methods of treatment (i.e. Brainspotting, EMDR, or Hypnotherapy) will be provided by the therapist.

Therapist's Responsibilities to a Client:
I. Confidentiality
With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. Your therapist cannot divulge identifying information to anyone nor acknowledge you as a client to anyone without your written consent. However, your therapist may legally speak to another health care provider or a member of your family about you without your prior consent, but will not do so unless the situation is an emergency (Healthcare Information Act of 1992). Even with written authorization, your therapist will always act so as to protect your privacy. You may per permit your therapist to share information with whomever you choose, you can change your mind and revoke that permission at any time. You may also request anyone you wish to attend a therapy session with you.

The following are legal expectations to your rights to confidentiality. Your therapist will inform you of any time when they think they will have to put these into effect:

1. If there is good reason to believe that you will harm another person, your therapist must warn the authorities of your intentions and must ask them to protect your intended victim.

2. If there is reason to believe that you are abusing or neglecting a child or a vulnerable adult, or if you give them information about someone else who's doing this, your therapist must inform child protective services within 72 hours. This is true for every professional person in Texas. Professionals are legally bound to report to the police or to child protection services any evidence of child abuse or abuse to vulnerable adults it is admitted during your professional contacts or is even reasonably suspected.
3. If there is cause to believe that you are in imminent danger of harming yourself, your therapist may legally break confidentiality and call the police or other legal authorities. They are not obligated to do this, and would explore all other options with you before they took this step.
4. If you or someone involved with you files a complaint or are a plaintiff in a lawsuit where you/they bring up the question of your mental health, you will have already automatically waive your rights to the confidentiality of these records in the context of the complaint or lawsuit in matters of subpoena or complaint responses. It can be discussed with your therapist about obtaining a protective order to help maintain confidentiality of records. Please let your therapist know if you are in this kind of situation so that they can take the utmost care possible to protect your privacy regarding records.
5. It is possible that in the future, various organizations (i.e. the State Bar, graduate schools, high security government agencies, etc.) may request information concerning the services rendered. This information will be forwarded only with your written consent.
6. Your therapist will not make electronic recordings of any contacts or interviews without your specific written permission.
7. Couples therapy – if you or your partner decide to have individual sessions coinciding with your couple or family therapy, what you say in those individual sessions will be considered to be a part of the couple or family therapy, and can and probably will be discussed in joint sessions. Do not tell your therapist anything you wish to keep secret from her partner or family members who are in treatment with you, as collusion is avoided to protect the therapy. Although not a legal exception to your confidentiality, you should be aware of this policy. If a couple wishes to see the same therapist individually and have separate files, the couple agrees that each's confidentiality will be protected. If this creates a problem in the marital or individual treatments, the client will be transferred to another therapist to continue care.
8. At times, your therapist may consult with a professional colleague to gain greater insight and feedback about their work. If they do so, they will not use your name or any information that could identify you without your written consent.
9. If your therapist is away from the office for professional meetings, court appearances, vacations, etc., they will tell you in advance to the best of their ability of any planned absences.

II. Record Keeping

Your therapist will keep very brief records, including attendance, payment made, what was done in the session, and a brief description of topics discussed. If you preferred the no records be kept, you must give written request to this effect for your file. You have the right to a copy of your file at any time (Healthcare Information Act, 1992). You have the right to request that your therapist correct any errors in your file. You also have the right to request that they make a copy of your file available to any other health care provider at your written request. Your therapist will maintain your records in a secure location in the office, and on a secured computer, which cannot be entered by anyone else. **NOTE:** Any text, voicemail, or email communication is part of your clinical record. Take care in discussing clinical or sensitive issues through this media.

III. *Diagnosis*

If a third-party, such as a state agency or insurance company, is paying for part of your bill, your therapist will be required to give a diagnosis to that 3rd party in order for reimbursement to be paid. if your therapist uses a diagnosis, it may be discussed with you. If you wish to understand your diagnosis, it may be discussed with your therapist or you may reference it from the book entitled DSM-V easily accessed through this office or online. Your therapist will be happy to guide you in finding the accurate information reflecting your diagnosis and treatment concerns. Your therapist will not alter types of service, treatment records, or diagnoses in order for insurance/third party payers to cover services.

IV. *Other Rights*

You have the right to ask questions about the therapeutic process. Your therapist is happy and willing to discuss how and why they decide to do what they are doing and to entertain alternatives that might work better for you. you are welcome to offer your therapist something that you think will be helpful. you can ask your therapist about their training for working with your concerns, and can request that they refer you to someone else if you decide they are not the right therapist for you. You are also free to leave therapy at any time.

V. *Managed Mental Healthcare*

If your therapy is being paid for in full or in part by a third-party agency (i.e. insurance companies, DARS, probation/parole, church subsidiary), such agency contracts may further limit your rights as a client. These may include their decision to limit the number of sessions available to you, to decide the time. Within which you must complete your therapy, or to require that you use medication if they are reviewing professionals deem it appropriate. They may also decide that you must see another therapist in their network if your therapist is no longer a vendor on their list. Such entities also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. Your therapist does not have control over any aspect of their rules. However, the therapist will do all that one can to maximize the benefits received by filing necessary forms and gaining required authorization for treatment, and assist you in advocating with the agency as needed.

VI. Your Responsibilities as a Therapy Client:

You are responsible for coming to your session on time and at the time scheduled. If you are late, your session will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours' notice, you must pay for that session at your next regularly scheduled meeting unless arrangements have been made otherwise. The voicemail/email/text systems have a time and date stamp which will keep track of time to cancellation. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads).

All private pay therapy sessions must be paid at the time received; the office will not allow a client to run a balance. If you find that you are having a hard time paying for therapy, please discuss it with your therapist. We only have a percentage of slots in our practice reserved for lower-fee clients, and if one of those is open, we would make it available. Or, you and your therapist could meet less frequently. If your financial circumstances improve, please let your therapist know so that the low-fee slot can become available to someone else. The office does not accept barter for therapy, nor take coupons. Any overdue bills will be charged a monthly late fee. If you eventually refuse to pay your debt, the office reserves the right to give your name and the amount due to a collection agency.

You have the right to choose when therapy ends, with 3 exceptions:

1. If your therapist has contracted for specific short-term piece of work, they will normally finish therapy at the end of that contract.
2. If your therapist believes they cannot help you, either because of the kind of problem that you have because their training and skills are not sufficient, your therapist is required to inform you of this fact and to refer you to another therapist who can meet your needs. They will continue to meet with you until you have established a relationship with a new therapist and would assist you in finding this person.
3. If you do violence to, threaten, or harass the therapist, the office, or anyone in their family, they reserve the right to terminate you unilaterally and immediately for treatment. They will do all that they can't work with you to prevent such an episode from occurring if it appears possible.

Complaints

If you are unhappy with what is happening in therapy, you should talk about it with your therapist so that they can respond to your concerns. Please allow us the opportunity to rectify the matter if possible. Your therapist will take such criticism seriously, and with care and respect. If you believe that they have been unwilling to listen and respond, or that they have behaved unethically, you can complain about such behavior to either the Texas Department of State Health Services, (512) 834-6658, PO Box 149347, Austin, TX 78714. You are also free to discuss your complaints about them with anyone you wish, and do not have any responsibility to maintain confidentiality about what they do that you don't like, since you are the person who has the right to decide what you want kept confidential.

NOTE: If a client files a complaint or lawsuit against the therapist, the treatment will terminate immediately as will all communication thereafter. If someone associated with the client files a complaint or lawsuit against the therapist, the therapist will determine the need to terminate treatment with that client on a case-by-case basis.

Client Consent to Psychotherapy

I have read and understand the above information and consent to receiving treatment by my therapist:

Client: _____ Date: _____

Parent or Guardian: _____ Date: _____

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CONFIDENTIALITY & CONSENT FOR SERVICES

The Therapy Process:

The goal of therapy is to improve functioning in areas that you feel is important. Therapy is an enlightening process, accomplished by raising awareness of problem areas and creating better ways of coping and problem solving. As unmanaged issues surface through the therapeutic process, stress sometimes increases before functioning improves – this is a natural part of the healing process. My therapeutic approach follows a combination of systemic therapy and Cognitive-Behavioral theory, allowing for self-awareness, relationship skills, and tools to improve your life. Please feel free to ask any questions about the therapeutic process and discuss any discomfort you may experience, as your comfort in the therapeutic relationship and process is important. Termination of therapy is an important process; please make arrangements with me to terminate to ensure a smooth transition for you.

Confidentiality:

I hold your confidentiality in the highest regard and will take all measures possible to protect your identity and information. Specific information pertaining to your care will not be released to anyone except for specific billing purposes or court orders relating to a criminal case or investigation (including communications with your probation/parole officer). Your information is protected under both state and federal confidentiality laws. However, there are limitations and exceptions to confidentiality as required by law and professional ethics codes:

1. Information of physical, sexual, or negligent abuse/exploitation to children, elderly, handicapped persons, & patients in mental health facilities, are required by law to be reported to the Texas Department of Protective and Family Services, even if the case has already been reported by others.

2. Any probability of harm to yourself or others will result in any efforts to protect you or others from imminent danger. If you report committing a crime, the local authorities will be notified.

3. If subpoenaed by the court, including but not limited to criminal prosecutions, divorce matters, child custody issues, the release of records, suits in which the mental health of a party is in issue, and/or verbal testimony will be required.

4. If couple or family therapy is conducted, all parties agree to engage in couple/family therapy that may include both joint and individual sessions. All parties understand that rights to confidentiality in individual sessions are waived to the other parties and are willing to waive that right so that information shared in individual sessions may be shared during joint sessions. If such rights are not wished to be waived, referrals for individual therapy by another provider in conjunction with the couples/family therapy will be offered as your P.F. DOVER COUNSELING and HYPNOSIS, PLLC therapist believes in the feelings of safety for all parties involved.

5. Other possible exceptions include but are not limited to: AIDS/HIV transmission/infection, situations where the therapist has a duty to warn or disclose, FEE DISPUTES between therapist and client, and in a negligence suit or licensing board complaint brought by the client or someone in connection to the client against the therapist.

Treatment Recording:
Recording of any kind by a client or accompanying party is not permissible in treatment. All electronic devices with recording capabilities will be turned off during group/individual sessions. Any recordings obtained without permission is take very seriously and will be subject to legal action.

If client is a minor:
Parents have a right to receive progress reports on their child's counseling. However, personal information shared by a child during an individual session will be kept confidential unless it involves imminent danger to the child or someone else. Young people will not confide in a counselor if they believe that personal information will be revealed to their parents; maintaining their trust is a priority. If there are situations that you may wish to know about yet may not be in the best interest of your child's treatment for your therapist share with you, your therapist's goal will be to encourage your child to reveal this information on his or her own. Regardless, your therapist will discuss and agree upon what situations warrant the sharing of information in the best effort to keep parents informed and active in the child's care.

I affirm that I am the legal guardian of _____ (sign if applicable for minor) and hereby grant permission for my child to participate in counseling services at this facility. I (we) do hereby give my (our) consent for therapy and/or related services at this facility. I (we) understand that all information pertaining to my (our) services shall remain completely confidential except in cases where confidentiality is limited. These limits of confidentiality, as prescribed by Texas law, have been explained to me (us). I (we) further understand that any release of information concerning my (our) services shall occur only with my (our) written consent.

Client: _____ Date: _____

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HIPAA CONSENT FORM

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations"). The Notice of Privacy Practices is provided to you and describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise my Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of the Notice at any time. You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, as indicated in the HIPAA Notice, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

"I hereby consent to the use or disclosure of my Protected Health Information as specified above. I understand that as part of my healthcare, my therapist originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment, psychotherapy notes, and any plans for future care or treatment. I understand that this information is used to plan my care and treatment, to bill for services, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals. I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without I prior written authorization, except as otherwise provided by law."

I have been provided the *Notice of Privacy Practices*, as indicated by my signature below.

Signature: _____ _____
Client or Legal Representative Date

Witnessed: _____ _____
Scott Smith/Privacy Officer Date

P.F. Dover Counseling and Hypnosis, P.L.L.C.
300 Trophy Club Dr.
Trophy Club, TX 76262

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

I, _____, do hereby authorize my treatment provider,
Scott Smith, MA, LPC, LCPC

to interact with: Emergency Contact/Relationship: _____Phone: _____

Please check consent for me to contact this person on your behalf regarding:
_____ Appointment Schedule ____ Emergencies _____ Clinical ____ Other _____

I do hereby authorize my treatment provider, to:

◊ Disclose **ANY AND ALL** protected health information regarding myself or my child, including but not limited to psychotherapy notes

◊ Receive **ANY AND ALL** protected health information regarding myself or my child, including but not limited to psychotherapy notes

◊ Exchange **ANY AND ALL** protected health information regarding myself or my child, including but not limited to psychotherapy notes

To/from the following persons/agencies:
Insurance Company _____
☐ (*If Applicable)* Probation/Parole Officer: _____ *Phone #*: _____
☐ Other(s) _____
_____
_____

This information is to be provided at my request for use by the entity specified above only in connection with:

- Continuity of Care
- Treatment Planning/Evaluation
- Insurance Verification
- Exchange Information
- Records/Reports
- Other: _____

This authorization shall expire on _____ or _____ be ongoing and/or on the conclusion of any and all appeals.
(*Check)*

I have the right to revoke this authorization in writing at any time to the extent that my therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be compelled by Court Order under state law as indicated in the copy of the *Privacy Notice* that I have received and reviewed. I acknowledge that I have been advised by my therapist of the potential of redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule. I further acknowledge that the treatment provided to me by my therapist is not conditioned upon my signing this authorization.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payers and/or other health practitioners. In the event that P.F. Dover Counseling and Hypnosis, PLLC should accept third party payments, I authorize and request my insurance company or other source to pay directly to P.F. Dover Counseling and Hypnosis, PLLC benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and that I may be responsible for uncovered costs. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give P.F. Dover Counseling and Hypnosis, PLLC, the right to seek services of a bill collecting agency in efforts to collect fees that my insurance company or other third party payor has not paid for services rendered and/or for cancelled or missed appointments.

This Release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164. As a covered entity that is acting in reliance on this Release, my therapist and P.F. Dover Counseling, PLLC, shall be released from liability, which may result from disclosing my individually identifiable health information and other medical records.

Signature: _____ _____

Client or Legal Representative Date

P.F. Dover Counseling and Hypnosis, P.L.L.C.
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Client History

Date: _____

Client Name: _____

What brings you to therapy? _____

What are your treatment goals? _____
_____

What helped in your previous treatment? _____
_____

What did not help in your previous treatment? _____
_____

Previous Therapy (check all that apply):

Outpatient Therapy: With Whom? _____
When/How long? _____
What issues were addressed? _____
Did this treatment help? _____
Why did it end? _____

Day Hospital (PHP/IOP):
Facility _____ When/How long? _____ ___# Times
What issues were addressed? _____
Did this treatment help? _____

In-Patient Hospitalization
Facility _____ When/How long? _____ ___# Times
What issues were addressed? _____
Did this treatment help? _____

Rehab/Detox
Facility _____ When/How long_____ ___# Times
What issues were addressed? _____
Did this treatment help? _____

Psychiatrist
MD Name: _____
When/How long? _____
Issue Treated: _____
Previous Diagnosis: _____

Psychotropic Medication (names, dosages, dates):

Name Dose Frequency Taken Regularly

_____
_____
_____
_____

History of Suicide Attempts: (List month/year)

_____

Method _____ Treatment _____

History of Homicide Attempts: (List month/year)

_____

Method _____ Treatment _____

History of Psychosis: ___Auditory ___Visual ___ Delusions ___ Paranoia ___ Tactile
Please Describe: _____
Age of onset: _____ Age of diagnoses/first treatment: _____
Treatment history:

_____

History of Self Injury (e.g., cutting, burning, etc.):
(List month/year)_____
Method _____ Treatment _____

Family Psychiatric History: Relationship to You Type of Treatment Issue

_____
_____

History of Trauma (Sexual, Physical, Emotional, Neglect:

_____
Effect: ___ Depression ___ Anxiety ___ Panic Attacks ___ Flashbacks ___ Nightmares ___Intrusive Thoughts
Avoidance of Specific Anxiety Provoking Situations due to Trauma: _____
Trauma Treatment History: _____

Self-esteem estimate: On a scale of 1 to 10, with 10 being high self-esteem, where is yours? _____
What things would improve your self-esteem: _____

Medical History (please provide dates):
Family Doctor: _____ Significant Weight Gain/Loss Appetite Gain/Loss
Health Problems: _____
Surgeries: _____
Medical Treatments: _____
Illnesses: _____
History of Head Injury/Trauma: _____
Resulting Effects: _____
Current Medications:
Name Reason Dose Frequency Taken Regularly

_____
_____
_____
_____

Chemical History:

N/A Social Drinker Social Drug User Alcohol Abuse Drug Abuse *Illegal/Prescription*

Alcohol of Choice: _____ Age of 1st Drink: _____ Addiction Problem? _____

Drug(s) of Choice: _____ Age of 1st Use: _____ Addiction Problem? _____

Current Abuse? Y / N Previous Abuse? Y / N Length of Sobriety: _____

Drug Use (Check all that apply):

	Type/Name	*Length of Use*	*Amount*	*Frequency*	*Last Used*
Alcohol					
Amphetamines					
Barbiturates					
Cocaine					
Hallucinogens					
Heroine					
Inhalants					
Marijuana					
Nicotine					
Opiates					
Tranquilizers					
Prescription					

History of Withdrawal Symptoms? Y / N Blackouts? Y / N

Psychosocial History:

Circle One: Single, Married, Partnered, Divorced, Widowed, Long-Term Relationship, Recent Break-Up

Living With: _____

Children (Names/Ages) _____

Pregnancies _____ # Full-Term Births _____ # Deceased Children _____

Marriages (Names/Dates) _____

Describe your relationship with: Your Mother _____

Your Father _____

Your Siblings _____

Paternal Grandparents _____

Maternal Grandparents _____

Current Social Support: _____

Conflicts with family (Immediate or Extended) _____

Academic History: Learning Disorders: ___ 504 PLAN: ___ Alternative Programs: ___

Social Problems: ___ Academic Problems: ___ Home Schooled: ___

Suspended: ___ Expelled: ___ Held Back a Grade: ___

Education: High School Graduate: ___ GED: ___ College Degree(s): ___

Work History: Stable: ___ Erratic: ___ No Work History: ___

Current Employer and Length of Employment:

Satisfaction with Current Employer:

Previous Employer:

Criminal History:

Juvenile

Arrest	Charge	Outcome	Probation Type/Length	Jail Time	Prison Time	Parole Length

Revocations: # of times _____ Violations _____
Did you successfully complete? Yes No

Adult

Arrest	Charge	Outcome	Probation Type/Length	Jail Time	Prison Time	Parole Length

Revocations: # of times _____ Violations _____
Did you successfully complete? Yes No

Place of Birth: _____

Relevant Places and Dates Where You Have Lived: _____

Additional Areas of Concern: