Atascocita Counseling Associates
Krissy Cotten, MA, LPC

Adult New Client Profile

Please complete the following as accurately and as completely as possible. Social Security Number is required only if you are filing with insurance.

Today's Date: _____

Name: _____

Date of Birth: _____ SS#: _____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different):_____

City: _____ State: _____ Zip: _____

Home Phone: _____ OK to Leave a Message? **Y N**

Work Phone: _____ OK to Leave a Message? **Y N**

Cell Phone: _____ OK to Leave a Message? **Y N**

Email: _____ OK to Send a Message? **Y N**

Employer: _____Occupation/Job Title: _____

Insurance Co: _____ Insurance Phone: _____

Subscriber ID: _____ Group #: _____

Name of Insured: _____D.O.B_____ Relationship: _____

Insured's Address:_____Employer_____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Home Phone: _____ Other Phone: _____

How did you hear about my practice? _____

If you were referred by a person, may I have permission to thank them? **Y N**

Phone 832-576-5538
Fax 888-891-2398
krissy@cotten.com

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18700 W. Lake Houston Pkwy. Ste.102
Humble, TX 77346

Personal History:
What is you marital status?
___Married
___Divorced
___Separated
___Single
___Dating

Do you have children, and if so, please list their ages?

_____

How many times have you been married? _____

Married _____ # of Years

Educational History:

Please check your highest level of education.

____High School

____College

____Graduate or Professional School

Presenting Problem:

What prompted you to seek counseling?

_____

How long has this been a significant concern for you?

_____

When did you first notice this problem?

_____

How has this problem affected you?

At home:_____

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At school/work:_____

Community:_____

Please check which of the following symptoms you have experienced:

__overeating
__recent weight loss
__recent weight gain
__recent appetite changes
__restlessness
__rapid heart rate
__anxiety
__fears/phobias
__muscle tension
__compulsive behaviors
__obsessions
__taking drugs
__drinking alcohol
__shortness of breath
__sweating
__vomiting
__stomach problems
__chest pain
__pain
__dizzy or lightheaded
__odd behavior/thoughts
__trembling or shaking
__difficulty concentrating
__distrust
__aggressive behavior
__outbursts of temper
__low motivation
__social withdrawal
__feelings of worthlessness
__depressed mood
__thoughts of hurting self or others
__crying
__easily distracted
__fatigue/loss of energy
__nightmares
__sleeping too much
__decreased need for sleep
__difficulty falling asleep
__difficulty staying asleep
__family emotional problems
__relationship problems
__housing problems

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__financial problems
__problems with school
__experienced a traumatic event
__hearing voices/seeing things
__other: _____

Have you ever intentionally harmed yourself?_____

Attempted suicide?_____

Harmed others?_____

Psychiatric and Medical History:

Please list any psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs).

Diagnosis	Length of Stay	Treatment	Response

Please list any current or prior outpatient psychiatrists and therapists you have seen?

Name	Title	Location	How Long?

Please list current **psychiatric** medications. Please attach a separate sheet if you need to list additional medication.

Name	Dosage	Duration	Response

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Please list current **non-psychiatric** medications.

Name	Dosage	Duration	Response

Please describe any significant medical illnesses or diagnoses:

_____

Family History:

Please check if there is any family history of the following:

___Depression
___Anxiety
___ADHD
___Bipolar (manic depressive)
___Schizophrenia
___Alcohol/Drug Problems
___Learning Disabilities
___Autism/Asperger/Pervasive Developmental Disorder
___Mental Retardation
___"Nervous Breakdown"
___Psychiatric Hospitalizations
___Suicide (or attempts)
___Panic Disorder
___PTSD (Post Traumatic Stress Disorder)
___OCD (Obsessive Compulsive Disorder

Personal Abuse History

Have you ever been the victim of abuse or neglect? Yes No

If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical Emotional Neglect Sexual Witnessing violence

Other:_____

Substance Use:

Have you ever felt the need to cut down on your drinking? Yes No

Have you ever felt annoyed by criticism of your drinking? Yes No

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Have you ever felt guilty about your drinking? Yes No

How many drinks (beer, wine, or hard liquor) do you consume each week, on average? _____

How much tobacco do you smoke or chew each week?_____

Have you ever used prescription medication for purposes it was not intended?

_____

Have you ever used illegal drugs? _____

Other:
To what type of faith do you and/or your family adhere?

_____

What are your favorite activities?

_____

Who can you or family count on for support?

_____

In the past, what has been helpful in dealing with your issues?

_____

Is there anything else you feel is important for your therapist to know that we have not asked about on these forms?

_____

Client Signature:_____

Date:_____

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Policies/Informed Consent

Please read this agreement and sign at the end indicating that you understand and agree to the following. I would like to introduce these policies and procedures to you so that there are no misunderstandings in the future. Please ask any questions if you would like clarification or additional information.

1. I counsel primarily from the Adlerian perspective using supportive techniques. Its mission is to encourage the development of psychologically healthy and cooperative individuals, children, couples, and families in order to effectively pursue the ideals of social equality and democratic living. An optimistic and inspiring approach to psychotherapy, it balances the equally important needs for optimal development of the individual as well as social responsibility.
2. **Fees**: My fee for an individual 45-50 minute session is $150. Payment is due at the time services are provided. Group therapy, when available, is $50 per 45-50 minute group session.
3. There are fees associated with work provided outside of your therapy session. Telephone consultations that exceed 10 minutes are billed at a rate of $3 per minute. Reports and letters generated at your request, and exceeding 10 minutes of work are $75 per 30 minutes.
4. **Forensic Rates:** $1500 for legal testimony or deposition; $200 per hour (prorated) for local transportation, waiting, and preparation for legal testimony or deposition. Consultation with attorneys or litigants (in person or via phone), report writing, review of records, and any other service associated with a legal dispute will be billed at a rate of $200 per hour (prorated). If I am subpoenaed or otherwise committed to appear in a legal case involving you, and the appearance is cancelled with less than 48 hours notice, you will be billed $1500 to offset the cost of a lost day of my work. These rates are enforced whether you, or another litigant in a case involving you have compelled me to become involved. Failure to keep your account current may result in legal action or collection agency intervention.
5. Each session will be about 45-50 minutes in length. If you arrive late to your session, that time will be taken out of our meeting. I will consider you a "no show" if you have not arrived or called 15 minutes past our appointment time.
6. If you need to cancel or to reschedule an appointment, I require 24 hours advance notice. Cancellations made with less than the required 24 hours will be charged the full session fee for the missed appointment.

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7. Payment is due at the time of the visit unless you and I have made other arrangements. I accept cash, personal checks and debit cards. Returned checks are subject to an additional service charge of twenty dollars. As a courtesy, I will provide you with a statement which is necessary to file an insurance claim upon request. It is your responsibility to file and discuss any issues concerning your reimbursement with your insurance company.
8. You have the right to terminate our relationship at any time, for any reason.
9. Please give me seven (7) days' notice if you decide not to work with me anymore.
10. I also reserve the right to terminate our relationship, and will provide referrals to other therapists or health practitioners in that event.
11. Our discussions will remain confidential. The only exceptions to this rule are if you threaten to harm yourself or someone else, or in a response to court mandates. In these cases, I am required by law to report our conversation to the proper authorities.
12. I will strive to support you and/or family in the therapeutic journey as we work toward reaching set goals. Many clients do reach their goals, but I cannot guarantee this outcome.

Acknowledgement and Consent

By signing these polices, I
(1) Acknowledge that I have been given a chance to review and ask questions about the *Policies and Practices to Protect the Privacy of Your Health Information*,
(2) Understand that the counselors associated with Atascocita Counseling Associates are all sole practitioners and any legal action taken against one of the psychotherapists may not include the others.
(3) Understand and agree to the stated practice polices as listed above and
(4) Give full consent for myself or my minor child,
_____, to participate in psychotherapy/ counseling.
I certify that I have the legal right to seek and authorize treatment for my minor child or myself.

_____ _____
Client Signature (or parent/guardian if client is a minor) Date

_____
Print Name

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize and direct:

Name (individual, clinic, institution): _____

Address: _____

Contact Number: _____

To provide to the office of Krissy Cotten, located at 18700 West Lake Houston Parkway, Suite 102, Humble, TX 77346, any and all medical records and/or additional and alternative information as noted below:

_____

_____

_____

By my initials, I provide authorization for Krissy Cotten, to disclose information to the above named: _____.

*Disclosure may include records that have information regarding diagnosis and treatment of drug, alcohol, substance abuse, AIDS, or psychiatric disorders but is/are not limited to these areas. **To the party receiving this information**: This information has been disclosed to you from records whose confidentiality may be protected by Federal Law. If so, Federal regulations (42CFR, Part 2) prohibit you from and further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Signature of Client/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

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PRIVACY POLICY

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996.

My Commitment to your privacy: I am required by law to maintain the confidentiality of your health information and must provide you with the following information:

The following circumstances may require me to disclose your health information:

- To public health authorities and health oversight agencies authorized by law to collect information.
- In response to a court administrative order in lawsuits or similar proceedings.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or health and safety of another individual or the public. I will disclose to a person or organization able to help prevent the threat.
- If you are a member of the U>S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security authorities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
- For Workers Compensation or similar programs.
- Your rights regarding your health information:
- You can request communication about your health and related issues in a particular manner or at a certain location. For instance, you may ask that I contact you at home, rather than work. I will accommodate reasonable requests.
- You can request restriction in my disclosure of your health insurance for treatment, payment, or operation. You can request that I restrict disclosure of health information to certain individuals. I am not required to agree to your request; however, if I do agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary for treatment.
- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including medical records and billing records, but excluding psychotherapy notes.

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- You may ask me to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for my practice. To request an amendment, request must be in writing and provide a reason that supports your request for amendment.
- You are entitled to receive a copy of this notice of privacy at anytime.
- If you believe your privacy rights have been violated, you may file a complaint with my practice or with the Secretary of the Department of Human Services.
- All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- I will obtain your written authorization for usage and disclosure of health information that are not identified by this notice, or permitted by law.

I hereby acknowledge that I have been presented with a Notice of Privacy Practice.

_____

Patient Printed Name Patient Signature Date

_____

Guardian Printed Name Guardian Signature Date

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CREDIT CARD AUTHORIZATION FORM

Please Print

Credit card billing information:		
Name:		
Email Address:		
Credit card type:	❑ Visa ❑ MasterCard ❑ American Express	
Credit Card #:		
Enter cvc #:	For Visa and MasterCard, the last 3 digits on back of card: For American Express, the 4 digits on face of card:	
Expiration Date:		
Billing Address;		
City:		
State:		
Zip Code:		
Phone Number:		
Please complete following payment options:		
Dates of service:	Bill my credit card <u>each</u> <u>visit</u> for the following amount	$
	Bill my credit card for <u>each</u> <u>missed</u> appointment for the following amount:	$
I agree all information provided is accurate and complete. I also acknowledge services may be immediately terminated at Krissy Cotten, MA, LPC's discretion if any charges are declined or charge backs are claimed against any outstanding amount. Disputes to amounts should immediately be reported to Krissy Cotten, MA, LPC. Likewise, changes in the status of this card can also be reported to Krissy Cotten, MA, LPC.		
The undersigned is the dully-authorized representative of the above cardholder.		
Authorized Signature:		Date:

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