ADULT
PATIENT REGISTRATION SHEET
Patient Information - Please fill out completely

DATE: _____ ( ) NEW ( ) UPDATE Email: _____

Name: _____ Home Phone #: _____ Cell #:_____

(Y/N) OK to call or leave messages: _____ Home #: _____ Cell #: ____ OK to email RE: appts? _____

Address: _____ City, State & Zip: _____

Gender: _____ Date of Birth: _____ Age: _____ Social Security #:_____

Marital Status: ( ) Single ( )Married ( )Separated ( )Divorced ( )Widowed

Name of Spouse/Significant Other (if applicable): _____

Spouse Date of Birth: _____ Spouse Social Security #: _____

Parent's Name (if minor) _____Work #: _____ Cell #:_____

Emergency Contact, Relationship & Phone #: _____

Medical History

Allergies: _____ Current Medications: _____

Primary Care Physician: _____ Psychiatrist: _____

Insurance Information

Is this a work-related injury/illness? Yes No

Primary Insurance:

Name of Carrier _____ Insured ID #: _____

Employer _____ Group #: _____

Address _____ Policy Holder: _____

City _____ State _____ Zip_____ Insured DOB: _____

Work # _____ Insured SS#: _____

Secondary Insurance:

Name of Carrier _____ Insured ID #: _____

Employer _____ Group #: _____

Address _____ Policy Holder: _____

City _____ State _____ Zip_____ Insured DOB: _____

Work # _____ Insured SS#: _____

ADULT CHECKLIST OF CONCERNS

IDENTIFYING INFORMATION **Date: _____**

Name: _____ Sex: _____ DOB: _____

Age: _____ Referral Source: _____

CHIEF COMPLAINT(S):

Presenting Problem(s): (check all that apply)

_____ Depressed/Unhappy	_____ Impulsive	_____ Stressed
_____ Irritable	_____ Stubborn	_____ Stealing
_____ Temper Outbursts	_____ Lonely	_____ Lying
_____ Withdrawn	_____ Racing Thoughts	_____ Sexual Trouble
_____ Daydreaming	_____ Unable to Relax	_____ Headaches
_____ Fearful/Anxious	_____ Relationship Problems	_____Palpitations
_____ Clumsy	_____ Cannot keep a job	_____ Insomnia
_____ Overactive	_____ Financial Problems	_____ Appetite Disturbance
_____ Slow	_____ Self-mutilating	_____ Fatigue
_____ Short Attention Span	_____ Over-ambitious	_____ Child of an addict
_____ Distractible	_____ Feel Inferior	_____ Legal Issues
_____ Lacks Initiative	_____ Undecisive	_____ Drug Use
_____ Undependable	_____ Strange Behaviors	_____ Alcohol Use
_____ Shy	_____ Strange Thoughts	_____ Suicidal Thoughts
_____ Phobic	_____ Memory Problems	_____ Prior suicidal attempt(s)
_____ Occupation Problems	_____ Learning Problems	_____ History of abuse
_____ Poor Impulse Control	_____ Over-spending	_____ Risk taking behavior

OTHER: _____

_____

What happened that makes you seek help at this time: _____

_____

Problems perceived to be: _____ very serious _____ serious _____ not serious

What changes would you like to see in yourself: _____

_____

AUTHORIZATIONS & ASSIGNMENTS FOR OUTPATIENT SERVICES

(Initial next to each paragraph & sign at the bottom of 2nd page)

_____**Application for Voluntary Services**: I hereby request outpatient services from Kingwood Counseling Center, PLLC on a strictly voluntary basis. My reasons for seeking treatment are purely self-motivated and are free from any undue influence or outside forces and in no way constitutes any promise of exchange or social services.

_____**Authorization for Treatment**: I hereby authorize my therapist to treat my condition. I understand that no warranty or guarantee has been made to me as to the results that may be obtained. I understand that it may be the professional opinion of my therapist to refer me to a psychiatrist, psychologist, or another therapist as may be deemed necessary for additional consultation and/or evaluation. I understand that I may choose to accept or reject any recommendation and/or referrals made by my therapist.

_____**Waiver and Release from Liability**: I agree to abide by the rules and regulations of this office governing the use of the office and/or building facilities located at 1521 Green Oak Place, Suite 250, Kingwood, Texas 77339 and any other office location. I assume all responsibility for myself and my dependents or family members and release Kingwood Counseling Center, PLLC staff, agents, governing bodies and professional staff from all responsibility for any event occurring during my use of these facilities and for my condition as a result thereof.

_____**Statement of Confidentiality**: I understand that any communication between my therapist and myself is kept in the strictest of confidence unless I have given expressed written and signed consent to the contrary. I also understand and agree that the following communications may not be held in confidence: plans for suicide, homicide, or known criminal activity. I hereby hold harmless and indemnify Kingwood Counseling Center, PLLC for any breeches of confidentiality under such conditions.

_____**Consent to Verify Employment and/or Insurance Benefits**: I hereby authorize Kingwood Counseling Center, PLLC to verify my employment and/or insurance benefits by contacting the personnel department at my place of employment or my insurance company directly.

_____**Physician, Psychologist, and/or Therapist Fees Billed Separately:** I understand that any outside Physician, Psychologist and/or Therapist fees are not included with those of Kingwood Counseling Center, PLLC. I understand that I must contact each provider for any information regarding his/her fees and make necessary arrangements to pay each separately and directly.

_____I understand and agree that I, and any dependents seeking treatment, will be billed separately for each session. I also understand that I will be billed separately for individual, group, and/or family therapy sessions.

_____I understand that no session will be billed that has not taken place, but I will be billed for any scheduled session that I am not able to attend and do not cancel with Kingwood Counseling Center, PLLC a minimum of 24 hours prior to that appointment time. Sessions not cancelled in advance will be billed at a rate of $60. I understand that I am responsible for keeping my appointments as scheduled, notifying the office in advance of need to reschedule, and paying the $60 cancellation fee should I fail to cancel prior to 24 hours before the

appointment. **Fees for missed appointments are billed to the client, not to the insurance company and will be charged to the credit card on file.**

_____ I understand and agree that if Kingwood Counseling Center, PLLC is to appear in court on my behalf, the charges for court testimony are $125 per hour including travel time to and from the courthouse. These charges are to be paid in advance, but no later than the day of the court testimony.

_____I understand and agree that payment is due at the time services are rendered unless other arrangements have been made with Kingwood Counseling Center, PLLC. I may contact Kingwood Counseling Center, PLLC during regular business hours regarding any billing questions.

_____I understand that should I have any questions, concerns or complaints regarding the therapeutic services provided by Kingwood Counseling Center, PLLC, I may contact the Texas State Board of Social Worker Examiners at (512) 834-6677 or the appropriate licensing board for my therapist.

_____I have read the above and have had an opportunity to ask any questions I may have regarding the aforementioned. Furthermore, as indicated by my initials and my signature below, I fully understand and agree to these terms.

_____ _____
Printed Name of Client Date

_____ _____
Client Signature (age 16 or older) Date

_____
Signature of Responsible Party or Legal Guardian

_____
Signature of Provider and/or Witness

KINGWOOD COUNSELING CENTER, PLLC
1521 Green Oak Place, Suite 250, Kingwood, Texas 77339
281-608-1346 I 832-436-1648

Patient's Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact Kingwood Counseling Center, PLLC at 281-608-1346.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of your primary care physician or another specialist. When we refer you to a specialist, we will share some or all your medical information with that physician to facilitate the delivery of your care.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information during judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena.
- Pertains to a victim of crime and you are incapacitated.
- Pertains to a person who has died under circumstances that may be related to criminal conduct.
- Is about a victim of crime and we are unable to obtain the person's agreement.
- Is released because of a crime that has occurred on these premises.
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas Workers' Compensation Law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations
The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we be ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Was not created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, email, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the Texas Behavioral Health Executive Council. We will not retaliate against you for filing a complaint with the government or us. The contact information for the Texas Behavioral Health Executive Council Services is:

Texas Behavioral Health Executive Council
HIPAA Complaint
333 Guadalupe St., Ste. 3-900
Austin, Texas 78701
Tel. (512) 305-7700
1-800-821-3205 24-hour, toll-free complaint system

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Kingwood Counseling Center, PLLC
1521 Green Oak Place, Suite 250
Kingwood, Texas 77339

This notice is effective on the following date: August 1, 2020.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

KINGWOOD COUNSELING CENTER, PLLC
1521 Green Oak Place, Suite 250, Kingwood, Texas 77339
281-608-1346 I 832-436-1648

Acknowledgement of Review of Notice of Privacy Practices & of the Office Policies of Kingwood Counseling Center

I, _____, have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I have also reviewed this office's Office Policies and I acknowledge that I have received a copy of these documents.

_____ _____
Signature of Patient or Guardian/Representative *Date*

_____
Name of Patient

_____
Description of Guardian or Representative's Authority

Note: This document will be placed in your medical chart and will become permanent medical record documentation.

CREDIT CARD AUTHORIZATION FORM

Please provide the following information:

Cardholder's Name: _____

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Credit Card Number: _____

Expiration Date: _____ / _____ CCV: _____ Billing Zip Code: _____

_____ I authorize and agree for Kingwood Counseling Center, PLLC to charge the credit card provided above for the copay, coinsurance, or patient responsibility as determined by my insurance provider.

_____ I authorize and agree for Kingwood Counseling Center, PLLC to charge the credit card provided above for the previously discussed amount per session should I be a Self-Pay patient without insurance benefits.

_____ I authorize and agree for Kingwood Counseling Center, PLLC to charge the credit card provided above for the amount of $60.00 should I fail to comply with Kingwood Counseling Center, PLLC's Cancellation policy as stated in the Authorizations and Assignments for Outpatient Services.

_____ I understand that should I choose not to provide Kingwood Counseling Center, LPPC with credit card information and fail to comply with Kingwood Counseling Center, PLLC's Cancellation Policy as stated in the Authorizations and Assignments for Outpatient Services, it will be at the discretion of the clinician and/or Kingwood Counseling Center, PLLC if future appointments are to be scheduled.

I understand that any information provided will remain confidential and shall not be used for any reason other than those agreed upon above. I also agree that I will pay for this purchase in accordance with the issuing cardholder agreement.

_____ _____

Signature Date

_____

Signature of Provider and/or Witness

KINGWOOD COUNSELING CENTER, PLLC
1521 Green Oak Place, Suite 250
Kingwood, Texas 77339
Credit Card Authorization

KINGWOOD COUNSELING CENTER, PLLC

281-608-1346 I 832-436-1648
1521 Green Oak Place, Suite 250
Kingwood, Texas 77339
info@kingwoodcounselingcenter.com
www.kingwoodcounselingcenter.com

OFFICE POLICIES

Kingwood Counseling Center, PLLC provides outpatient individual, family, and marital psychotherapy to assist with resolution of issues related to relationships, anger, communication, self-esteem, grief, stress, and mental illness. Please feel free to discuss any questions you may have regarding treatment, treatment goals or policies.

APPOINTMENTS: Appointments are made by calling 281-608-1346 or in office after your appointment. Appointments are 45-60 minutes long and the number of sessions will be determined by the patient and therapist. If your sessions are being paid for by insurance, sessions must be approved by your insurance carrier. Regular appointments are important to produce maximum possible benefits, but you are free to discontinue treatment at any time.

PAYMENT: Your co-payment, or full payment if you are self-pay, is due at the time of each appointment. Credit cards are accepted for your convenience. The charge for court testimony is $125 per hour, including travel time to and from the courthouse or attorney's office.

CANCELLATION: If you need to cancel an appointment, please call the office at least 24 hours in advance. There is a $60 charge for appointments missed without 24-hour prior notice unless there is a verifiable medical or family emergency and this fee will be charged to the credit card on file in the event of a missed appointment.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

1. Where there is a reasonable suspicion of child abuse or abuse to a dependent or elder person.
2. When the client communicates a threat of bodily injury to others.
3. When the client is suicidal.
4. There is physical injury due to violence.
5. When disclosure is required pursuant to a legal proceeding.

EMERGENCY PROCEDURES: In case of a mental health crisis, call the office number and we will make every effort to return your call as quickly as possible. In the event of a psychiatric or medical emergency such as suicidal thinking or attempt, reaction to medication, etc, it is imperative that you call 911 or go to the nearest hospital emergency room.