

SOUTHWEST PSYCHOTHERAPY ASSOCIATES

Micki Grimland, LCSW, ACSW
Dianne Pulsipher, MA, LPC

Samantha Rushing, M.Ed., LPC, CWC
Sue Steinbruecker, LCSW, ACSW

NEW PATIENT DATA

(Please Print Clearly)

Patient's Name: _____ Age: _____ Birthdate: _____

Gender: _____ Marital Status: _____ Education: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell Phone Number: _____

Employer: _____ Occupation: _____

Work Address (Adults Only): _____

City: _____ State: _____ Zip: _____ Work Telephone: _____

E-mail _____

Referred By: _____

Reason for Referral: _____

Previous Mental Health Contacts or Evaluations: _____

Family Physician: _____ Ph# _____

Approximate Date of Last Contact: _____ Overall Health Status: _____

List Any Chronic Health Conditions: _____

Current Medications: _____

List ALL Members of your Family and their ages: _____

I have read the fee schedule and the policy on payment of fees.

Signature of Patient, or Legally Responsible Adult: _____

Health Insurance Company: _____

Group Number: _____ Member Number: _____

Social Security Number: _____

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CLIENT'S INFORMED CONSENT AND STATEMENT OF UNDERSTANDING

I have chosen to receive services by a Southwest Psychotherapy Associate. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no guarantee that I will feel better. Because psychotherapy is a cooperative effort between my therapist and myself, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

Limits of Confidentiality

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that, in accordance with state and local laws, my therapist is required to report and will report all cases in which there exists a danger to self or others, and cases in which my therapist may suspect abuse or neglect of a person (child, elderly, developmentally disabled) who is presumed to be unable to protect self.

I understand that if I use my insurance benefits to help pay for my therapy, it will be necessary for my therapist to disclose to the insurance company my diagnosis and in some cases information which establishes the medical necessity for treatment. This information will become a part of permanent insurance record. Insurance claims will be filed directly by the client. This office does not file insurance claims.

Emergencies

A therapist will be on call when my therapist is on vacation. My therapist's phone number is (713) 952-1742. I have written this number down.

I understand that answering services are not perfect communication devices. If I do not hear from my therapist or the therapist on call within a reasonable period of time, I will leave another message at the office number. In extreme emergencies, or if the phone system has failed, you may call her cell phone. (Be sure to obtain this number from your therapist.)

I have read and understand the above.

Signature of Client

Date

Signature of Therapist

Date

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FEE SCHEDULE AND POLICY ON PAYMENT OF FEES

The hourly rate for therapy is \$_____ . Additional time will be charged accordingly. Phone calls will be charged the hourly rate. The client is responsible for payment of all fees. Payment will be made at the end of each session. Insurance claims are to be processed for direct reimbursement by the client. If any account goes unpaid, a service charge of 1.5% will be added. 18% APR will be added to all overdue accounts. The client will also be liable for all legal and collection fees.

A 24 hour notice will be given if a session has to be cancelled. If a 24 hour notice is not given, the session will be charged to the client's account.

Special arrangements are possible through written agreement by the client and the therapist.

Date

Client Signature

Therapist Signature