



Personal Information

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Male ___ Female ___ Minor ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Address: _____

City, State, Zip: _____ Referred by: _____

Employer: _____ Occupation: _____

Referred by: Yellow Pages; Insurance Company; Other: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Where would you like us to leave reminder messages: Home ___; Work ___; Cell Phone ___; Email ___; None ___

If there is emergency at the office and we must cancel the appointment, where should we call: _____

In the event of an emergency with you, whom should we contact: Name: _____

Relationship: _____ Work # _____ Home # _____

Who is responsible for this account?

Name: _____ Relationship to Patient: _____

Birthdate: _____ Soc. Sec. # _____

Address: _____

City, State, Zip: _____

Employer: _____

Occupation: _____ Work # _____ Home # _____

Authorization and Release:

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 payors and/or other health practitioners.

I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Anisha Shah, MA, LPC the right to seek the services of a bill-collecting agency in efforts to collect fees that I have not paid to her for services rendered and/or for cancelled or missed appointments.

Copy and/or any outstanding balance may be charged to my credit card. ___ VISA ___ MC

Card Number _____ Expiration Date: _____

X _____
Signature of patient or parent if minor

Date

ALL ABOUT YOU

About Your Education:

Where did you attend public school? _____

Did you attend college? When, where? _____

Any plans to further your education? _____ If so, when and what? _____

About Your Relationships:

Please list your marriage(s) or other important significant other relationships

	Spouse's name	Year Begun	Year Ended	Married to this person?	Children from this relationship and their ages
#1					
#2					
#3					
Please list all people who live with you					

About Your Family:

Relative	Name	Living?	Current age, or age at death	Deceased? Yes or No	Occupation
Father					
Mother					
Brother(s)					
Sister(s)					
Any other significant person?					

About Your Health:

Who is your Doctor? _____ Last Visit: _____ Concerns? _____

Do you have any chronic medical concerns? _____. If so, please list: _____

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had:

List *all* medications or drugs (legal or illegal) you take or have taken in the last year.

ABOUT YOUR CONCERNS

Please mark all of the items below that currently apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- | | | |
|--|---|---|
| <input type="checkbox"/> Abuse-emotional | <input type="checkbox"/> Health | <input type="checkbox"/> Self Abuse-burning |
| <input type="checkbox"/> Abuse-neglect | <input type="checkbox"/> Hostility | <input type="checkbox"/> Self Abuse-cutting |
| <input type="checkbox"/> Abuse-physical | <input type="checkbox"/> Impulsive spending | <input type="checkbox"/> Self Abuse-other |
| <input type="checkbox"/> Abuse-sexual | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Self Abuse-scratching |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Indecision | <input type="checkbox"/> Self-centeredness |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Self-control |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Inhibitions | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Interpersonal conflicts | <input type="checkbox"/> Self-neglect |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Career concerns | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sexual conflicts |
| <input type="checkbox"/> Childhood issues
(your own childhood) | <input type="checkbox"/> Judgment problems | <input type="checkbox"/> Sexual desire
differences |
| <input type="checkbox"/> Children-care | <input type="checkbox"/> Laziness | <input type="checkbox"/> Sexual dysfunctions |
| <input type="checkbox"/> Children-custody | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Sexual-(other issues) |
| <input type="checkbox"/> Children-management | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Choices I have made | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Sleep-insomnia |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Losses | <input type="checkbox"/> Sleep-nightmares |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Low energy | <input type="checkbox"/> Sleep-too little |
| <input type="checkbox"/> Compulsive spending | <input type="checkbox"/> Low frustration
tolerance | <input type="checkbox"/> Sleep-too much |
| <input type="checkbox"/> Concentration
Problems | <input type="checkbox"/> Low income | <input type="checkbox"/> Step parenting |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Low mood | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Marital coldness | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Marital conflict | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Debt | <input type="checkbox"/> Marital distance | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Marital infidelity/affairs | <input type="checkbox"/> Temper problems |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Medical concerns | <input type="checkbox"/> Tension/Stress |
| <input type="checkbox"/> Dependence | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Thought
disorganization |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Menopause | <input type="checkbox"/> Threats of violence |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Mixed feelings | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Drug Abuse-over-the-
counter medications | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Drug Abuse-
prescription
medications | <input type="checkbox"/> Motivation | <input type="checkbox"/> Work Problems |
| <input type="checkbox"/> Drug Abuse-street
drugs | <input type="checkbox"/> Mourning | <input type="checkbox"/> Weight and diet issues |
| <input type="checkbox"/> Drug Abuse-Alcohol | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Withdrawal, isolating |
| <input type="checkbox"/> Eating-poor appetite | <input type="checkbox"/> Outbursts | <input type="checkbox"/> Employment problems |
| <input type="checkbox"/> Eating-making myself
vomit | <input type="checkbox"/> Oversensitive to
criticism | <input type="checkbox"/> Employment-lack of |
| <input type="checkbox"/> Eating-overeating | <input type="checkbox"/> Over-sensitive to
rejection | <input type="checkbox"/> Employment-
overdoing |
| <input type="checkbox"/> Eating-under-eating | <input type="checkbox"/> Panic or anxiety
attacks | <input type="checkbox"/> Employment-
Terminations |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Parenting | <input type="checkbox"/> Other Concerns: |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Perfectionism | _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pessimism | _____ |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Phobias | _____ |
| <input type="checkbox"/> Financial troubles | <input type="checkbox"/> Physical problems | _____ |
| <input type="checkbox"/> Friendship problems | <input type="checkbox"/> PMS | _____ |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Poor self-care | _____ |
| <input type="checkbox"/> Goals not being met | <input type="checkbox"/> Procrastination | _____ |
| <input type="checkbox"/> Grieving | <input type="checkbox"/> Relationship problems | _____ |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Relaxation | _____ |
| <input type="checkbox"/> Headaches, pains | <input type="checkbox"/> Re-marriage | _____ |
| | <input type="checkbox"/> Risk taking | _____ |
| | <input type="checkbox"/> Sadness | _____ |
| | <input type="checkbox"/> School problems | _____ |

ABOUT ANISHA SHAH MA, LPC

Please Initial Each Paragraph:

I understand that Anisha Shah is a Licensed Professional Counselor in the state of Texas and holds a B.S. in Childhood Education, and a M.S. in Human Development. She also holds an M.A. in Clinical/Counseling Psychology from Southern Methodist University, Dallas, Texas.

I understand that Anisha Shah works with children, adolescents, and adults in individual, group, and family counseling.

I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.

I understand that if I am concerned about slow progress or lack of progress I have the right to speak to Anisha Shah about this.

I understand that Anisha Shah does not perform formal testing but refers individuals to those who do.

I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Anisha Shah to tell someone else in writing or verbally, b) Anisha Shah determines that her client poses a threat to them self or others, c) She is ordered by a court to disclose information, or d) She suspects that child abuse has taken place, at which time he will notify Child Protective Services.

I understand that counseling can improve as well as upset the equilibrium in any person or family.

I understand that if I have a complaint I cannot resolve with Anisha Shah and I wish to file a formal complaint I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to Anisha Shah.

I understand that there is a returned check fee of \$25.00 and that if a returned check is not cleared up in 30 days Anisha Shah will file a suit with the Dallas County District Attorney's Office.

I understand that all co-pays are due at the time of service.

I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of \$60.00.

I understand that the rate for an initial session is \$125.00 and for subsequent sessions is \$125.00. These fees are for 45-minute sessions.

I understand that Anisha Shah is not a psychiatrist, she is a Master's level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medication evaluation.

By signing below I confirm that I have read, agree to and received the above information:

Client/Parent of Client Date Received and Read

This copy is for you to read, sign, and leave with Anisha Shah

ABOUT ANISHA SHAH MA, LPC

Please Initial Each Paragraph:

I understand that Anisha Shah is a Licensed Professional Counselor in the state of Texas and holds a B.S. in Childhood Education, and a M.S. in Human Development. She also holds an M.A. in Clinical/Counseling Psychology from Southern Methodist University, Dallas, Texas.

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By signing below I confirm that I have read, agree to and received the above information:

Client/Parent of Client Date Received and Read

This copy is for you to read, sign, and keep for your records

Notice of Privacy Practices

**Kirkland Clinical Associates
Richardson, Texas**

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 office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services.

You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of April 14, 2003

THIS IS YOUR COPY TO KEEP

Acknowledgement of Receipt Of Notice of Privacy Practices
For
Kirkland Clinical Associates

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

Patient: _____ Date: _____
(If patient is a minor, Parent or guardian must sign)

Consent For use and Disclosure of Health Information

I hereby permit Kirkland Clinical Associates to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

Patient Signature: _____ **Date Signed:** _____
(Parent or Guardian if Patient is a Minor)

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Please see our Notice of Privacy Practices for more complete description. You will find this Notice of Privacy Practices on our website at WWW.DanKirkland.com and in a notebook in the waiting room. This Notice of Privacy Practices is also provided to you in your intake packet. If this consent is revised in the future, you may obtain a revised copy from this office.