



**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/ Who is the Insured?**

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 authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Kirkland Clinical Associates the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him for services rendered and/or for cancelled or missed appointments.

X \_\_\_\_\_  
Signature of patient or parent if minor Date



### 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"/> Headaches, pains               | <input type="checkbox"/> School problems              |
| <input type="checkbox"/> Abuse-neglect                               | <input type="checkbox"/> Health                         | <input type="checkbox"/> Self Abuse-burning           |
| <input type="checkbox"/> Abuse-physical                              | <input type="checkbox"/> Hostility                      | <input type="checkbox"/> Self Abuse-cutting           |
| <input type="checkbox"/> Abuse-sexual                                | <input type="checkbox"/> Impulsive spending             | <input type="checkbox"/> Self Abuse-other             |
| <input type="checkbox"/> Aggression                                  | <input type="checkbox"/> Impulsiveness                  | <input type="checkbox"/> Self Abuse-scratching        |
| <input type="checkbox"/> Anger                                       | <input type="checkbox"/> Indecision                     | <input type="checkbox"/> Self-centeredness            |
| <input type="checkbox"/> Anxiety                                     | <input type="checkbox"/> Inferiority feelings           | <input type="checkbox"/> Self-control                 |
| <input type="checkbox"/> Arguing                                     | <input type="checkbox"/> Inhibitions                    | <input type="checkbox"/> Self-esteem                  |
| <input type="checkbox"/> Attention Problems                          | <input type="checkbox"/> Interpersonal conflicts        | <input type="checkbox"/> Self-neglect                 |
| <input type="checkbox"/> Career concerns                             | <input type="checkbox"/> Irresponsibility               | <input type="checkbox"/> Separation                   |
| <input type="checkbox"/> Childhood issues<br>(your own childhood)    | <input type="checkbox"/> Irritability                   | <input type="checkbox"/> Sexual conflicts             |
| <input type="checkbox"/> Children-care                               | <input type="checkbox"/> Judgment problems              | <input type="checkbox"/> Sexual desire<br>differences |
| <input type="checkbox"/> Children-custody                            | <input type="checkbox"/> Laziness                       | <input type="checkbox"/> Sexual dysfunctions          |
| <input type="checkbox"/> Children-management                         | <input type="checkbox"/> Legal matters                  | <input type="checkbox"/> Sexual-(other issues)        |
| <input type="checkbox"/> Choices I have made                         | <input type="checkbox"/> Loneliness                     | <input type="checkbox"/> Shyness                      |
| <input type="checkbox"/> Codependence                                | <input type="checkbox"/> Loss of control                | <input type="checkbox"/> Sleep-insomnia               |
| <input type="checkbox"/> Compulsions                                 | <input type="checkbox"/> Losses                         | <input type="checkbox"/> Sleep-nightmares             |
| <input type="checkbox"/> Compulsive spending                         | <input type="checkbox"/> Low energy                     | <input type="checkbox"/> Sleep-too little             |
| <input type="checkbox"/> Concentration                               | <input type="checkbox"/> Low frustration<br>tolerance   | <input type="checkbox"/> Sleep-too much               |
| <input type="checkbox"/> 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<br>ideas)                  | <input type="checkbox"/> Medical concerns               | <input type="checkbox"/> Tension/Stress               |
| <input type="checkbox"/> Dependence                                  | <input type="checkbox"/> Memory problems                | <input type="checkbox"/> Thought<br>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-<br>counter medications | <input type="checkbox"/> Mood swings                    | <input type="checkbox"/> Violence                     |
| <input type="checkbox"/> Drug Abuse-<br>prescription<br>medications  | <input type="checkbox"/> Motivation                     | <input type="checkbox"/> Work Problems                |
| <input type="checkbox"/> Drug Abuse-street<br>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<br>vomit               | <input type="checkbox"/> Oversensitive to<br>criticism  | <input type="checkbox"/> Employment-lack of           |
| <input type="checkbox"/> Eating-overeating                           | <input type="checkbox"/> Over-sensitive to<br>rejection | <input type="checkbox"/> Employment-<br>overdoing     |
| <input type="checkbox"/> Eating-under-eating                         | <input type="checkbox"/> Panic or anxiety<br>attacks    | <input type="checkbox"/> Employment-<br>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"/> Re-marriage                    | _____   |
|  | <input type="checkbox"/> Risk taking                    | _____   |
|  | <input type="checkbox"/> Sadness                        | _____   |

**ABOUT DAN KIRKLAND MS, MS, LPC-S, RPT**

Please Initial Each Box:

- I understand that Dan Kirkland is a Licensed Professional Counselor in the state of Texas and a Registered Play Therapist and holds a B.S. and an M.S. in Counseling from Texas A&M-Commerce, Texas.
- I understand that Dan Kirkland 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 Dan Kirkland about this.
- I understand that Dan Kirkland 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 Dan Kirkland to tell someone else in writing or verbally, b) Dan Kirkland determines that his client poses a threat to them self or others, c) he is ordered by a court to disclose information, or d) He 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 can not resolve with Dan Kirkland 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 Dan Kirkland.
- 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 Dan Kirkland 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 that must be paid at my next scheduled appointment.
- 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 Dan Kirkland is not a psychiatrist, he is a Master’s level therapist, and as such can not 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 is for you to read, understand, sign, and leave with Dan Kirkland

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This is for you to read, understand, 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 it's 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.kirklandclinical.com](http://www.kirklandclinical.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.