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 Elizabeth Tober, M.A., LPC, MT-BC 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.

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

About Your Child's Education

Age: ________ Grade: _____ Nick Names: _________ Failure or Held Back? ____________________

What do school personnel tell you about your child? ____

Grade	**School**	**Average Gr**	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

About Your Child's Family

Relatives	Name	Age/Grade	Does Child Get Along Well with this Person?	Occupation
Father				
Mother				
Sister(s)				
Brother(s)				
Step Mother				
Step Sister(s)				
Step Brother(s)				
List all people who live in the home with this child:				

About Your Child's Routine

What kinds of physical exercise does your child get? ________________________________

How much coffee, cola, tea, or other caffeine does your child consume each day __________

Is your child's eating restricted in any way? How? Why? _____________________________

Bedtime: ______ Wake-up Time: _____ Hours of sleep on an average night: _______

Does your child have any problems getting enough sleep? ________(Please describe fully.)
____

About Your Child's Health

Who is your child's pediatrician? ______________ When was the last visit? _____________

Any Concerns shared by the doctor?____

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.
____

____

Describe any allergies your child has: ____

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-

counter, and others. Include dosages please___________________________________

List all prior counselors/dates/reasons: ____

Anything else you are concerned about? ____

(These Questions are regarding older children)

Is this child in a gang? _____ Has this child used drugs? _____. If so, describe which drugs,

frequency, age at first use, and amounts____

Has this child ever been pregnant or fathered a child? _____ If yes, please tell what happened with

each pregnancy: ____

Agreement for Therapy with a Minor:

I, ________________, the parent/legal guardian of the minor, ___________________,

- Give my permission for this minor to receive therapeutic services provided through Kirkland Clinical Associates.
- I have read, understood, and signed the informed consent related to my child's therapist and I understand the risks and benefits of receiving these services and the risks and benefits of *not* receiving these services, for both this minor and his or her family.
- Furthermore, I understand that I am expected to participate in this process by meeting with the therapist at least once per month while my child is in therapy.

My signature below means that I understand and agree with all of the points above.

____ __________
Signature of parent/guardian Date

About Your Child's Symptoms

Please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- ☐ Accident-prone
- ☐ Affectionate
- ☐ Aggressive
- ☐ Argues
- ☐ Assaults
- ☐ Bathroom language
- ☐ Bigoted
- ☐ Bossy to others
- ☐ Breaks rules
- ☐ Breaks the law
- ☐ Bullied by others
- ☐ Bullies others
- ☐ Cheats
- ☐ Clowns around
- ☐ Competition
- ☐ Complains
- ☐ Complains of feeling sick
- ☐ Compliant
- ☐ Concern for others
- ☐ Conflicts at school
- ☐ Conflicts at home
- ☐ Conflicts with friends
- ☐ Conflicts with police
- ☐ Cries easily
- ☐ Cruel to animals
- ☐ Dares others
- ☐ Dawdles
- ☐ Daydreams
- ☐ Defiant
- ☐ Dependent
- ☐ Destructive
- ☐ Developmental delay s
- ☐ Difficulties with parent's partner
- ☐ Disobedient
- ☐ Disrupts family activities
- ☐ Distractible
- ☐ Dropping out of school
- ☐ Drug or alcohol use
- ☐ Drug sales
- ☐ Eating Issues
- ☐ Failure in school
- ☐ Fantasy life
- ☐ Fearful
- ☐ Feelings are easily hurt
- ☐ Fidgety
- ☐ Fighting
- ☐ Finger sucking
- ☐ Fire setting
- ☐ Friendly
- ☐ Hair chewing
- ☐ Head banging
- ☐ Hitting
- ☐ Hostile
- ☐ Hyperactive
- ☐ Hypochondriac
- ☐ Imaginary playmates
- ☐ Immature
- ☐ Inappropriate sexual behaviors
- ☐ Inattentive
- ☐ Independent
- ☐ Inflicts pain on others
- ☐ Insults others
- ☐ Interrupts
- ☐ Intimidated by others
- ☐ Intimidates others
- ☐ Intolerant
- ☐ Irritability
- ☐ Isolates
- ☐ Lacks organization
- ☐ Lacks respect for authority
- ☐ Learning disability
- ☐ Legal difficulties
- ☐ Lethargic
- ☐ Likes to be alone
- ☐ Loitering
- ☐ Loss of friends
- ☐ Low frustration tolerance
- ☐ Lying
- ☐ Manipulates
- ☐ Masturbation
- ☐ Mental retardation
- ☐ Moody
- ☐ Mute, refuses to speak
- ☐ Nail biting
- ☐ Name calling
- ☐ Needs for high degree of supervision
- ☐ Negativism
- ☐ Nervous
- ☐ New school
- ☐ Nightmares
- ☐ Noisy
- ☐ Noncompliant
- ☐ Obedient
- ☐ Obesity
- ☐ Only younger playmates
- ☐ Oppositional
- ☐ Outgoing
- ☐ Out-of-seat behaviors
- ☐ Overactive
- ☐ Picks on others
- ☐ Poor concentration
- ☐ Pouts
- ☐ Prejudiced
- ☐ Procrastinates
- ☐ Provokes others
- ☐ Rages
- ☐ Recent move
- ☐ Refuses
- ☐ Relationships with friends
- ☐ Relationships with siblings
- ☐ Relationships with teachers
- ☐ Resists
- ☐ Responsible
- ☐ Restless
- ☐ Rocking or other repetitive movements
- ☐ Runs away
- ☐ Sad
- ☐ School avoiding
- ☐ Self-harming behaviors
- ☐ Sexual preoccupation
- ☐ Sexually active
- ☐ Shy
- ☐ Slow-moving
- ☐ Slow-responding
- ☐ Smart-alecky
- ☐ Smoking
- ☐ Social
- ☐ Speech difficulties
- ☐ Stealing
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing
- ☐ Talks back
- ☐ Talks out
- ☐ Teased
- ☐ Teases others
- ☐ Temper tantrums
- ☐ Threatens
- ☐ Thumb sucking
- ☐ Tics-movements or noises
- ☐ Timid
- ☐ Truancy
- ☐ Uncooperative
- ☐ Uncoordinated
- ☐ Under-active
- ☐ Unhappy
- ☐ Unprepared
- ☐ Vandalism
- ☐ Violent
- ☐ Wastes time
- ☐ Wetting/soiling of bed/clothes
- ☐ Withdraws
- ☐ Work problems
- ☐ Yells
- ☐ Any other characteristics:

____

____

____

____

____

____

____

____

____

ABOUT ELIZABETH TOBER, M.A., LPC, MT-BC
Please Initial Each Box:

- ☐ I understand that Elizabeth Tober is a Licensed Professional Counselor in the state of Texas, a Music Therapist-Board Certified, and holds a M.A. in Counseling Psychology from Texas Woman's University, Denton, Texas.
- ☐ I understand that Elizabeth Tober 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 Elizabeth Tober about this.
- ☐ I understand that Elizabeth Tober 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 Elizabeth Tober to tell someone else in writing or verbally, b) Elizabeth Tober 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 she 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 Elizabeth Tober and I wish to file a formal complaint I may contact the Texas Sate Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.
- ☐ 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 Elizabeth Tober 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 I am responsible for all fees that my insurance denies, rejects, or fails to pay to Elizabeth Tober.
- ☐ 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 each session is $125.00. These fees are for 45-minute sessions.
- ☐ I understand that Elizabeth Tober is not a psychiatrist, she 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 copy is for you to read, sign, and leave with Elizabeth Tober

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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 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.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.