

Kirkland Clinical Associates, LLC
331 Melrose Suite 130
Richardson, Texas 75080
Office: (972) 231-2555
Fax: (972) 231-2293

ADULT CLIENT INTAKE INFORMATION

About the Client:

Name: _____ Today's Date: _____
Birth date: _____ Age: ____ Soc. Sec. #: _____ Male ___ Female ___ Single ___ Married ___ Divorced ___ Separated ___
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____ Referred by: _____
If there is emergency at the office and we must cancel the appointment, where should we call: _____

Your emergency contact person: Name: _____ Relationship: _____
Their Work # _____ Their Home # _____ Their Cell Number _____

Who is responsible for this account?

Name: _____ Relationship to Patient: _____
Birth date: _____ Soc. Sec. # _____
Address: _____
City, State, Zip: _____
Employer: _____
Occupation: _____ Work # _____ Home # _____

Authorization and Release:

I authorize and request my insurance company to make payments directly to Kirkland Clinical Associates, LLC all 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, LLC 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 for services rendered and/or for cancelled or missed appointments. I understand that there is a fee for all sessions not cancelled with twenty four hours notice.

X _____
Signature of patient or parent if minor

Date

ALL ABOUT YOU

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	Occupation
Father				
Mother				
Brother(s)				
Sister(s)				
Step-Brother(s)				
Step-Sister(s)				

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.

- Current or Past Abuse
- Alcohol
- Anger
- Anxiety
- Attention Problems
- Career concerns
- Childhood issues (your own childhood)
- Children
- Choices I have made
- Codependence
- Confusion
- Crying
- Deaths
- Debt
- Decision making
- Delusions (false ideas)
- Dependence
- Depression
- Divorce
- Drug Abuse
- Eating Issues
- Emptiness
- Failure
- Fatigue
- Fears
- Financial troubles
- Friendship problems
- Gambling
- Grieving
- Guilt
- Health
- Hostility
- Impulsiveness
- Indecision
- Inferiority feelings
- Inhibitions
- Interpersonal conflicts
- Irritability
- Judgment problems
- Legal matters
- Loneliness
- Loss of control
- Losses
- Low energy
- Low frustration tolerance
- Low mood
- Marital coldness
- Marital conflict
- Marital distance
- Marital infidelity/affairs
- Medical concerns
- Memory problems
- Mood swings
- Motivation
- Obsessions
- Outbursts
- Oversensitivity
- Panic/anxiety attacks
- Parenting
- Perfectionism
- Pessimism
- Phobias
- Physical problems
- Relationship
- Sadness
- School problems
- Self Abuse
- Self-control
- Self-esteem
- Self-neglect
- Separation
- Sexual conflicts
- Sexual desire differences
- Sexual dysfunctions
- Sexual-(other issues)
- Sleep Problems
- Stress
- Suicidal thoughts
- Suspiciousness
- Temper problems
- Tension/Stress
- Threats of violence
- Tiredness
- Violence
- Work Problems
- Weight issues
- Withdrawal/Isolation
- Employment Issues
- Internet Pornography

Any Other Concerns: _____

Important Information for You to Know:**Please Initial Each Box:**

- I understand that the therapists at Kirkland Clinical Associate, LLC are licensed through the Texas State Board of Examiners of Licensed Professional Counselors and hold advanced degrees from accredited universities.
- 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 my therapist about this.
- I understand that my therapist 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 Kirkland Clinical Associate, LLC, or one of it's associates to tell someone else in writing or verbally, b) My therapist determines that I may pose a threat to myself or others, c) If KCA or one of it's associates is ordered by a court to disclose information, or d) that child abuse is alleged, at which time authorities will be notified.
- 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 KCA or one of its associates 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 \$35.00 and that if a returned check is not cleared up in 30 days KCA 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 KCA.
- 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 no associate at KCA can 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 a copy the above information:

Client/Parent of Client _____ Date Received and Read _____

(This copy is for you to read, understand, sign, and leave with your therapist)

This copy is for you to read, understand, and keep

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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.

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Insurance Verification Information

(Please Print)

About the Client:

Client's Name: _____ Client's Birth Date: _____ Client's SS #: _____

Client's Address: _____ City, State, Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

About the Insurance Holder:

Name: _____ Birth Date: _____ SS #: _____

Relationship to Client: _____ Employer: _____

About Your Insurance: (We will get your EAP info when we call the insurance company. This is not EAP Information)

Insurance Company: _____ Mental Health Phone #: _____
Group #: _____ Subscriber #: _____;
Is there an Employee Assistance Program (EAP) where you work? Yes / No / Don't Know

OFFICE PERSONNEL WILL COMPLETE ALL INFORMATION BELOW. PLEASE LEAVE BLANK

Date Verified: _____ Info from: Ins.Co. & Name: _____ Elect. Claims ID # _____

Therapist is: In net ___ Out net ___ # of Sessions Allowed/Year _____; Per Lifetime: _____;

This contract covers: **# of Sessions** **Authorization #** **Auth Effective These Dates**

90801	Diagnostic Evaluation	_____	_____	_____
90806	Individual Treatment	_____	_____	_____
90808	Extended Session	_____	_____	_____
90846	Family without Patient	_____	_____	_____
90847	Family with Patient	_____	_____	_____
90853	Group Therapy	_____	_____	_____

EAP Coverage **# of Sessions** **Authorization #** **Auth Effective These Dates**

EAP Sessions _____ _____ _____

Mental Health Claims Address: _____

- Co-Pay: \$ _____; or _____ % of allowed amount;
- Deductible: **Balance is \$ _____ as of the date verified.**
- **Annual Deductible is \$ _____ and starts over on: _____**
- Other: _____

PLEASE FAX THIS PAGE TO OUR OFFICE AS SOON AS POSSIBLE SO WE MAY VERIFY YOUR BENEFITS PRIOR TO YOUR APPOINTMENT