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

CLIENT INTAKE INFORMATION FOR COUPLES

***About the Client**: (Person insurance will be filed under)*

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:

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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 Client **Date**

ALL ABOUT HER

About Her 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 Her Family:

Relative	Name	Living?	Current age, or age at death	Occupation
Father				
Mother				
Brother(s)				
Sister(s)				
Step-Brother(s)				
Step-Sister(s)				

About Her 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 HER 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:____

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____

____

____

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Important Information for HER 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___________________________________ Date Received and Read________________

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

This copy is for Her to read, understand, and <u>keep</u>

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Notice of Privacy Practices

Kirkland Clinical Associates, LLC
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 HER COPY TO KEEP

Acknowledgement of Receipt of Notice of Privacy Practices
For
Kirkland Clinical Associates,LLC

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

Client Signature:____Date: ______________

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.

Client Signature: ____ Date Signed: ______________

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.

ALL ABOUT HIM

About His 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 His Family:

Relative	Name	Living?	Current age, or age at death	Occupation
Father				
Mother				
Brother(s)				
Sister(s)				
Step-Brother(s)				
Step-Sister(s)				

About His 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.

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ABOUT HIS 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.

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- ☐ Alcohol
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- ☐ Choices I have made
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- ☐ Confusion
- ☐ Crying
- ☐ Deaths
- ☐ Debt
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Any Other Concerns:____

Important Information for Him to Know:

Please Initial Each Box:

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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 Him to read, understand, sign, and leave with your therapist)

This copy is for Him to read, understand, and <u>keep</u>

<u>Important Information for Him to Know:</u>

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3. Facilitate payment by third parties for services rendered by us.
4. 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 HIS COPY TO KEEP

Acknowledgement of Receipt of Notice of Privacy Practices For Kirkland Clinical Associates, LLC

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

Patient Signature: ____Date: ______________

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: ______________

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

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 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 APPOINMENT