

Consent for Services

I request that Terri Lively, LCSW provide psychotherapy services to me and if applicable to my minor children.

I agree that fees for services are payable as follows:

Fees for services are due and payable at the time of **each** session.

OR

Fees for services will be paid by my health care plan except for co-insurance or deductible amounts and services not covered by my health care plan which are payable at the time services are provided.

My copay or agreed fee for service amount is _____ per session.

If I have a deductible to meet first, I agree to pay _____ per session until the deductible of _____ is met.

I agree to pay for any and all missed appointments unless I provide notice of cancellation 24 hours in advance. The charge for each missed appointment cancelled within a 24 hour period is \$105.00, which is the normal session rate effective May 1, 2004. I understand that insurance companies do not pay for missed appointments.

I have read this consent for services and agree to these terms.

Client Signature

Parent/Conservator's Signature (If client is a minor)

Date

Consent to Use and Disclose Your Health Information

This form is an agreement between you _____ and Sugar Creek Psychotherapy. When the word “you” is used below, it will mean your child or other person if you have written his or her name here _____.

In order to diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We may need to use this information to decide what treatment is best for you and be able to provide that treatment. We may need to share this information with your doctor or another health professional that provides treatment to you. Your insurance company has the right to contact us to ask questions about your treatment.

By signing this form, you are agreeing to let us use your information here and send it to the above noted others.

If you do not sign this Consent, we cannot treat you.

In the future we may change how we use and share your information or we may change our Notice of Privacy Practices. If we do, you can get a copy by calling us or our Privacy Officer at 281-494-9100.

If you are concerned about some of your information, you have the right to ask us to not use or share some of it for treatment, payment of administrative purposes. You will have to notify us in writing. Although we will try to respect and comply with your wishes, we are not required to agree to these limitations.

After you have signed this consent, you have the right to revoke it by writing a letter telling us you no longer consent and we will comply with your wishes from that time on. However, if we have already used or shared some of your information, that cannot be changed.

Signature of client or his/her personal representative

Date

Printed name of client or personal representative

Relationship to client

Description of personal representative’s authority

Confidential Information Sheet

Date: _____

Name	_____	_____	_____	Home Phone _____ <input type="checkbox"/>
	Last	First	MI	
Address	_____	_____	_____	Cell Phone _____
	Street	City	State ZIP	

If our office **MUST NOT** contact you either at work or home, please indicate with an **X** in box next to number

Age	_____	Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
Birthdate	_____		<input type="checkbox"/> Married	<input type="checkbox"/> Cohabitated	<input type="checkbox"/> Divorced
Social Security #	_____				

Are you currently employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation	_____
Company Name	_____		
Education: Check Highest Level Completed	High School	College	Post Graduate
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

Spouse's Name	_____	Occupation	_____
Age	_____	Years Married	_____
Birthdate	_____		
Social Security #	_____		
Education: Check Highest Level Completed	High School	College	Post Graduate
	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

Your Prior Marriages		Spouse's Prior Marriages	
From _____	To _____	From _____	To _____
From _____	To _____	From _____	To _____
From _____	To _____	From _____	To _____

Confidential Information Sheet (continued)

Who Referred You?	_____		
	Name	Relationship	
Person to Contact in Emergency	_____		
	Name	Relationship	Phone #

Why did you come to our office? _____

What are your goals through psychotherapy? _____

Have you ever been in psychotherapy? Yes No
 If yes, with whom and when? _____
 Was it helpful? _____

Have you ever been hospitalized for a mental or emotional problem? Yes No
 If yes, where and when? _____

List any medications you are taking: _____

Who prescribed these medications? _____

Do you have any significant physical problems? Yes No
 If yes, what are the problems? _____

Family History

Where did you grow up?

	Mother	Father
Living or deceased?	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
If living, how old? If deceased, when did he/she die?	_____	_____
Quality of relationship	<input type="checkbox"/> Excellent <input type="checkbox"/> Good	<input type="checkbox"/> Excellent <input type="checkbox"/> Good
	<input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Fair <input type="checkbox"/> Poor

Please list the names and ages of brothers and sisters and rate the quality of your relationship with each:

Name	Age	Quality of Relationship			
_____	_____	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
_____	_____	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

If you have children, please list names and ages of each:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Is there any history of mental or emotional problems in your family?

Is there any history of drug or alcohol abuse in your family?

Patient Insurance Information

Insurance Company	_____		
Phone # of Insurance Company	_____	Policy #	_____
Address of Insurance Company	_____		
	Street	City	State ZIP

Relationship to Insured	_____	Full time student?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Primary Insured Name	_____			
Primary Insured SS#	_____			
Employer	_____			

Is the Insured's address different from patient's address? Yes No

Secondary Insured Name (if any)	Name _____	Phone # _____
Secondary Insured SS#	_____	Secondary Insured Employer _____

Release of Information and assignment of benefits

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the therapist who accepts assignment for services.

Signed: _____ Date: _____