Renee' Austin M.Ed. LPC Intake Form
Cell: (281) 728 5933
Address: 17330 Preston Rd. Ste 200 D
Dallas Tx 75252
Phone (972) 318 2943

Patient Information

Patient's full name_____Marital Status: M S W D Sep

Home address_____How long_____

City_____ State_____
Zip_____
Phone: Home_____Work_____Cell_____

Ok to text: Y or N

Social Security#_____
Driver's License#_____
DOB_____Age_____Sex: M F
Religious Affiliation/Spiritual Beliefs_____
Occupation_____Employer_____

Others living in the home:
Name_____Birth date_____
Relationship_____
Name_____Birth date_____
Relationship_____
Name_____Birth date_____
Relationship_____
Name_____Birth date_____
Relationship_____

Who recommended this office?_____

Person to contact in case of emergency_____
Phone_____
Relationship to patient_____

Spouse or Parent name_____
DOB_____
Responsible party_____
Phone_____
Social Security #_____
DOB_____
Address_____City/St./Zip_____
_____

Primary Care
Physician_____Phone_____
Address_____City/St./Zip_____
_____

MEDICAL INSURANCE

Primary
Insurance_____Phone_____
Address_____City/St./Zip_____
Subscriber's
Name_____Employer_____
ID
#_____Group#_____

ALL OTHER INSURANCE ASSIGNMENT

I hereby authorize the release of medical information necessary for claims processing, and assign all insurance benefits to the billing therapist.
Signed_____
Date_____

ASSUMPTION OF RESPONSIBILITY FOR ADULT CHILDREN

I agree to be responsible for professional expense incurred
Date_____
Signed_____
Relationship to patient_____

CONFIDENTIALITY

Information shared will be held in confidence. It will not be released without your written consent, except for professional consultation if needed and unless required by law.
We are required by law to disclose information pertaining to suspected child, dependent adult and elder abuse inability to care for one's basic needs for food, clothing or shelter and threatened harm to oneself or others.
Lawyers may, in select cases, subpoena counseling records.
Information regarding treatment and diagnosis may be provided to your insurance company and/or our outside billing service for reasons among which are case review, payment review, benefit management, etc.
If you have concerns about disclosure of confidential medical information, please discuss this with your provider.

LEGAL EVALUATIONS

If you are involved in or anticipate being involved in legal or court proceedings, please notify your provider as soon as possible. It is important for them to understand how, if at all, your involvement in these proceedings might affect our work together. Charges for speaking to attorneys, court appearances, etc. apply. A minimum of 500$ will be charged for all court appearances and 150$ per hour after the first hour will be charged and payment is due on date of services rendered.

APPOINTMENTS

All office visits are by appointment and are scheduled with our receptionist (or your provider). Please arrive on time, as you lose minutes from your appointment time when you arrive late. The usual length of time for an intake or psychotherapy appointment is 45-50 minutes.
Cancellation and /or no-show appointments: Twenty-four (24) hours' notice is required if you must reschedule or cancel an appointment. No-show appointments will be billed to you for the full amount. If you are more than 15 minutes late you will pay the cash fee for your session as I

cannot bill insurance. We cannot bill insurance; insurance will not pay for late canceled or no-show appointments.
In the case of illness, please notify our receptionist or your provider as soon as possible and no later than 8:30 a.m. the day of the appointment. Please leave a voice mail message if our office is closed. You will not be charged when ill or if weather prevents you from driving.
If your appointment is canceled or missed, please re-contact our office for a new appointment time.

FEES

Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
Patients paying on a cash basis (not billing any insurance) are expected to make payment in full at the time of service, unless a payment plan has been previously arranged. We accept VISA/MC/Amer Ex and cash. NO checks.
Our office will bill your health insurance company if complete information is provided and proper authorization was obtained prior to the visit. Please verify whether your coverage includes outpatient psychotherapy by a licensed professional. If your policy requires pre authorization to receive services our office will assist you, but it is your responsibility to insure that it is handled prior to the visit. You are ultimately responsible for payment of your account.
Patient portions, co-payments and/or deductibles are due at the time of service. You will only receive statements if patient portions are due after insurance claims are processed. Statement balances are due by the
20th of the month.
Accounts become delinquent after thirty (30) days. Delinquent accounts may be sent to a collection agency.

Please initial if you agree:
_____ I have read, understood and agree to these policies and give consent for treatment.
Signature:_____
Date:_____
Patient Name:_____

PRESENTING PROBLEMS

Describe the problem that brought you here today:
_____
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Highlight or Check any of the systems that you are having:

o Depression
o Extreme Sadness
o Trouble Concentrating
o Memory Problems
o Change in Eating Habits
o Feeling of Extreme Happiness
o Trouble performing Your Job
o Lack of enjoyment of usual activities
o Self-esteem problem
o Perfectionism
o Obsessions or Compulsions
o Feeling fearful
o Physical complaints of pain
o Problems with anger
o Thoughts about hurting yourself or others
o Feeling hopeless
o Feeling tearful
o Change in sleeping habits
o Lack of energy
o Weight changes
o Change in sexual interest or function
o Problems getting along with friends or family
o Feeling Stressed
o Easily irritated
o Feeling Guilty
o Feeling nervous
o Sudden feelings of panic
o Muscle tension
o Acting violently
o Thoughts about killing yourself or others
o Binging, purging, restricting of food, use of laxatives or over exercising
o Nightmares, flashbacks, experiencing triggers of trauma

History of Abuse or Trauma:

_____
_____

HAVE YOU EVER BEEN IN COUNSELING BEFORE?

o Yes o No

When did you have counseling?_____
Dates_____
Who did you see?_____Name_____
Explain what happened:

_____
_____
_____
_____
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MEDICAL INFORMATION

Have you seen a doctor in the past year? o Yes o No
Why have you seen a doctor?

_____
_____
_____
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Who is your doctor?_____
Phone#: _____
Are you taking any kind of medicine (prescription or over the counter)? o Yes o No
Please list the medicines that you are taking:

_____
_____
_____
_____
_____
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Do you have allergies to anything? o Yes o No
Please describe allergy problems that you may have:

_____
_____
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SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form)? o Current o Past o No
Do you use/have you used alcohol? o Current o Past o No
Do you use/have you used caffeine? (any form including cola drinks)? o Current o Past o No
Do you use/have you used recreational drugs? o Current o Past o No