FAMILY COUNSELING CENTER ASSN.

CLIENT NAME:_____ADDRESS:_____

CITY:_____STATE:____ZIP:_____SS#: No longer need

PHONE NUMBER: HOME:_____ CELL:_____

PERSONAL DATA

DATE TODAY:_____ REFERRED BY:_____

INDIVIDUAL DATA

SEX:____ DATE OF BIRTH:___/___/___ AGE:_____

EDUCATION COMPLETED (GRADES, DEGREES OR COURSES)_____

YOUR LIFE: HAPPY:____ AVERAGE:____ UNHAPPY:_____ VERY UNHAPPY:_____

OCCUPATIONAL DATA

PLACE OF EMPLOYMENT:_____PHONE:_____

PREVIOUS EMPLOYMENT:_____PHONE:_____

ANNUAL INCOME BEFORE DEDUCTIONS: YOURS:_____MATE'S:_____

PHYSICAL HEALTH DATA

VERY GOOD:_____GOOD:_____AVERAGE:_____POOR:_____

LIST PRESENT ILLNESSES, INCLUDING ALLERGIES:_____

WHEN WAS YOUR LAST MEDICAL CHECK UP? (DATE):_____

FINDINGS:_____

LIST OR DESCRIBE PURPOSE(S) OF MEDICATION OF ANY KIND NOW BEING TAKEN:_____

YOUR PHYSICIAN:_____

ADDRESS:_____

Emergency contact person:Name:_____ph#_____

EMOTIONAL HEALTH DATA

HAVE YOU EVER HAD SERIOUS MENTAL DISTURBANCE OR A NERVOUS BREAKDOWN?_____IF SO, WHEN?_____

HAVE YOU HAD THERAPY BEFORE?_____ YES_____NO_____

WHEN?_____WITH WHOM?_____

HAVE YOU EVER WITNESSED OR BEEN EXPOSED TO A TRAUMATIC EVENT?_____

(This includes experiencing combat, witnessing an accident or death, being involved in a natural disasters--fire, flood, tornado, hurricane--or have you been the victim of abuse, sexual or otherwise, in childhood or as an adult.)

MARITAL AND FAMILY STATUS

MARRIED_____SINGLE_____ GOING STEADY_____ENGAGED_____

WIDOWED_____IF SO, WHEN?____/___/____

DIVORCED_____IF SO, WHEN? ____/____/____

MARRIED WHEN?____/____/_____

HOW LONG DATING MATE?_____

SPOUSE'S NAME_____

MATE'S AGE_____MATE'S EDUCATION_____MATE'S RELIGION_____

SEPARATED?_____IF SO, WHEN?____/____/____

PREVIOUS MARRIAGES:

HOW MANY?_____ HOW TERMINATED?_____

CHILDREN: AGE: DOB: COMMENTS:

_____

_____

_____

_____

ANY LEGAL ACTION PENDING? ____YES, _____NO

IF YES, DESCRIBE:_____

_____

RESPONSIBLE PARTY INFORMATION:

RELATIONSHIP TO PATIENT:_____

RESPONSIBLE PARTY NAME:_____

ADDRESS:_____

CITY, STATE & ZIP:_____

HOME PHONE:_____

SOCIAL SECURITY NUMBER:_____

DATE OF BIRTH:_____

OCCUPATIONAL INFORMATION:

EMPLOYER:_____

EMPLOYER ADDRESS:_____

WORK PHONE:_____

ANNUAL INCOME BEFORE DEDUCTION:_____

Family Counseling Center Association
2401 OAKLAND BLVD.
FORT WORTH, TEXAS 76103

STATEMENT OF INFORMED CONSENT

I, the undersigned, do hearby acknowledge, understand and consent to the following for psychotherapy and/or counseling service for myself and/or for _____ a minor of whom I am the parent or legal guardian.

1.) The psychotherapy and/or counseling will be conducted by a qualified psychotherapist/counselor.
2.) I understand according to the professional licensing law and professional ethics, these professional counselors are qualified to help me be released to experience further interpersonal and intrapersonal development.
3.) Specific objectives and methods are to be agreed upon in consultation with the therapist. I understand that a non-physician therapist will not prescribe medicine.
4.) The therapist is a consultant and resource professional. His/Her suggestions may be freely accepted or rejected by the client. Therefore, decisions made during and after therapy are the responsibility of the client.
5.) Consultations, test results and disclosures between the counselor and the client will be held in confidence within the restrictions of Texas state law. These exceptions to confidentially include cases in which: (1) illegal activity is occurring (such as physical or sexual abuse); (2) the purpose of counseling is to obtain a court evaluation; or (3) legal action regarding the therapy itself (such as a malpractice suit) is in progress.
The counselors are ethically and legally responsible to protect and maintain the counseling relationship while not in conflict with the basic laws of society.
6.) I affirm that I have read all the conditions above and that they have been fully explained to my satisfaction. I understand and agree to them freely and without reservation.

DATE_____

SIGNED_____WITNESS_____

CONSUMER COMPLAINT HOTLINE 1-800-942-5540

Family Counseling Center Association
2401 OAKLAND BLVD.
FORT WORTH, TEXAS 76103-3291
(817) 534-2818

FINANCIAL AGREEMENT FOR_____

90837	Individual Psychotherapy 60 minutes	_____
90834	Individual Psychotherapy 45 minutes	_____
90847	Family Psychotherapy	_____
90620	Consultation	_____
90887	Eval/Testing Feedback	_____
90889	Narrative Report	_____
90853	Group Psychotherapy	_____
90791	Diagnotice Eval/Interview	_____

I understand I am committing myself to be regular and punctual in meeting my appointments. The time is reserved for me whether I come or not, therefore, I understand the responsibility of paying the agreed amount until such time as the contract is modified or cancelled by agreement between me and the counselor. All sums due under the financial agreement are payable in Fort Worth, Tarrant County, Texas.

SIGNATURE_____DATE___/____/_____

_____
Family Counseling Center Assn.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above-named agency to release any information requested by attorneys, physicians, insurance companies, employers, health care providers, or any other entity which may be concerned with payment of the charges incurred at the Center.

_____ _____
Date Patient (Parent or Guardian if a Minor)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the Family Counseling Center Assn dba Center for Creative Living of the insurance benefits payable to me for services rendered by above-named agency.

_____ _____
Date Patient (Parent or Guardian if a Minor)

LATE CANCELLATION/ NO SHOW POLICY

Full fee will be charged for all sessions where you no show or late cancelled with less than twenty-four (24) hour notice given. If an insurance patient, you will be responsible for full fee as we can not bill insurance company when you do not show.

_____

Name

_____

Date