Please Complete Each Blank or Note Not Applicable "N/A"

Appointment Day/Date/Time:

____

HIPAA-COMPLIANT

INSURANCE VERIFICATION for Mental/Behavioral Health Care

Circle Y/N
and Initial

Home Phone _________________________________ OK Leave Msg? Y/N ___

Work Phone _________________________________ OK Leave Msg? Y/N ___

Client Cell Phone _________________________________ OK Leave Msg? Y/N ___

Spouse Cell Phone _________________________________ OK Leave Msg? Y/N ___

OK to Send Email Message? Y/N ___

Client Name[s]:____/____________________________
Last First Middle Spouse

Home Address: ____
Street City State Zip Code

Date of Birth: ________________ Social Security No.: ______________________

Email Address: ____

PRIMARY INSURANCE

Name of Insurance Company:____

Name of (circle one) HMO, PPO, or EAP, if applicable: ____

Claims Mailing Address for Mental/Behavioral Health Treatment:
(note: this is usually not the address on the back of the insurance card, and must be verified along with the other information requested here)

____
Street or PO Box City State Zip Code

Telephone Number(s): ____

Insurance ID No.: __________________________ Group No.: ___________________ Date Policy Effective:_____________

Relationship of Client to Insured (circle one): Self / Spouse / Child / if Other-specify ___________________________________

If** the **Client** is **not** the **Insured, please provide the following information ***for the Insured***: (numbers 1 through 5)

1) Name of Insured: ___________________________________ 2) Date of Birth of Insured: __________________

3) Social Security No. of Insured: _______________________ 4) Gender of Insured: (circle one) Male Female

5) Employer of Insured:________________________________ 6) Electronic Payor ID Number: ______________

Deductible? (circle one) Yes/No Amount of Deductible $ Deductible met for this Year? (Circle one) Yes/No

SECONDARY INSURANCE: ***If you do not have secondary insurance, please state "NONE" for insurance company***

Name of Insurance Company: ________________________________ Client Name: ____________________

Name of (circle one) HMO, PPO, or EAP, if applicable: ____

Claims Mailing Address *for Mental/Behavioral Health Treatment:* ***(note—This is usually not the address on the back of the insurance card, and must be verified along with the other information requested here)***

____

Street or PO Box City State Zip Code

Telephone Number(s): ____

Insurance ID No.: ____________________ Group No.: _______________ Date Policy Effective:__________

Relationship of Client to Insured (circle one): Self / Spouse / Child / if Other-specify ______________________________

If** the **Client** is **not** the **Insured, please provide the following information ***for the Insured:*** (numbers 1 through 5)

1) Name of Insured: ____________________________ 2) Date of Birth of Insured: ______________

3) Social Security No. of Insured: ___________________ 4) Gender of Insured: (circle one) Male Female

5) Employer of Insured:__________________________ 6) Electronic Payor ID Number: ___________

Deductible? (circle one) Yes/No Amount of Deductible $ Deductible met for this Year? (circle one) Yes/No

I understand that if I am unable to keep an appointment, I will advise the office at least 24 hours in advance, or I will be charged the full fee. I authorize the release of any medical or other information necessary to process any insurance claims, and authorize the payment of insurance benefits directly to Kit Jones, L.P.C., unless I am paying charges in full at the time of service. I will be responsible for any expense not covered by insurance. In the event that my account becomes past due, I understand that interest and collection charges may be added to my balance and applied to my credit card.

>Signed ____ Date ______________________<

(Office Use ONLY)

AUTHORIZATION DATA

CHECK ONE: EAP _____ PRIMARY _____ SECONDARY _____

NUMBER VISITS INITIALLY AUTHORIZED: _______________ TOTAL VISITS PER YEAR THIS POLICY ALLOWS:__ ______

AUTHORIZATION NUMBER(S): 1ST VISIT ____;

LATER VISITS ____________________________ **COPAY AMOUNT: $_________ COINS. AMT. $_ ________**

MAXIMUM BENEFITS: ____

MAXIMUM BENEFITS CONT'D**:**____

SMI COPAY AMOUNT: $_____________ NUMBER SMI VISITS AUTHORIZED: (IF APPLICABLE)______________________

MAXIMUM SMI BENEFITS FOR THE YEAR/LIFE (NOTE WHICH**):**____

____

POLICY YEAR: CIRCLE ONE **CALENDAR YEAR OR OTHER** _________________________ **TO** ______________________

Special Claim Form Needed? (circle one) Yes/No If Yes, Form Name/Number____________________________

OTHER PERTINENT AUTHORIZATION DATA: ____

Verified by: ____________________ ____________________ ______________

Counseling Center Staff Insurance Company Rep. Date

Demo-InsAuth2KJ91006

New Patient Registration

Patient Name ______________________________ Date of Birth ____________________

Social Security Number ____________________ Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed ☐ Other _______

Emergency Contact ____________________ Relationship to Patient ____________________

Emergency Contact Phone # (____) ____________________ Emergency Contact Phone # (____) ____________________

Place of Employment ____

Referral Source

Who may we thank for referring you to our clinic? ____

Chief Complaint

Problems/symptoms for which you are seeking treatment: ____

____

When did you begin experiencing these problems/symptoms? ____________________

Do you experience these problems/symptoms every day? ____________________

What prompted you to seek treatment now? ____________________

Where do you rate your presenting problem(s) today?

1	2	3	4	5	6	7	8	9	10
Least Severe									**Most Severe**

Previous Treatment

List all previous psychotherapy, counseling or other treatment you have received in the past:

Date	Type of Problem	Name of Practitioner	Inpatient/Outpatient	Results

Medical History

How would you rate your present physical health? ☐ Excellent ☐ Good ☐ Poor

When was your last physical exam? ____

Findings from that exam & lab results____

Current Medications (Prescription, Over-the-Counter, Herbs, Supplements, etc.)

Name	Dosage	Frequency	Date began	Doctor

Medical Conditions	Date Diagnosed	Name of Doctor Treating this Condition

Allergies ____

Adverse reactions or sensitivities to foods, drugs or other substances? ____________________

Symptoms

- ☐ Sleep Disturbance
- ☐ Poor Concentration
- ☐ Appetite Disturbance
- ☐ Crying Spells
- ☐ Low Energy
- ☐ Depressed Mood
- ☐ Mood Swings
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Sexual Problems
- ☐ Paranoid Thoughts
- ☐ Hallucinations
- ☐ Delusions
- ☐ Aggressive Behavior
- ☐ Oppositional Behaviors
- ☐ Obsessions/Compulsions
- ☐ Anorexia
- ☐ Bingeing/Purging
- ☐ Thoughts of Self-harm
- ☐ Attempted Suicide
- ☐ Thoughts of Harm to others

Substance	Amount	Frequency	For How Long	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Other					

Family History

Number of Children ___________ Age(s) of Children ________________________________

Number of Siblings ___________ Age(s) of Siblings ________________________________

Age of Parents Mother_____ Father ________

Is there a family history (parents, siblings, children) of psychiatric conditions or substance abuse? ______________

If Yes, who and for what condition? ________________________________

Development History

Were your development milestones (crawl, sit, walk, talk, etc.) met early, late or normal? ______________

Any complications during pregnancy or with labor/delivery? ________________________________

____

Social History

Education Completed (grade or degree) ________________________________

Marital History ________________________________

Occupation (# years at current job) ________________________________

Legal History (arrests, divorce, etc.)________________________________

Military Service (Branch, Rank, # years) ________________________________

Support Systems ________________________________

Spiritual Beliefs ________________________________

Patient/Guardian Signature________________________________ Date ______________

Signature

Kit Jones, M.Ed., L.P.C.

I am pleased that you have selected me as your counselor. This document is designed to inform you about my background and to ensure a clear understanding of our professional relationship.

Qualifications

The State of Texas licenses me as a professional counselor. I have a general practice dealing with a wide range of issues. My areas of special interest include, but are not limited to: marriage/separation/divorce, depression, grief recovery, addictions, codependence, sexual or other trauma, childhood abuse, and dysfunctional family issues.

Experience

I have counseled adults and teens—individuals, couples, families, and groups. I have over ten years' experience with the 12-Step program of Adult Children of Alcoholic/Dysfunctional Families.

Nature of Counseling

Since I believe all individuals have within themselves the capacity for growth and self actualization, the goal of therapy is for me to assist my clients in learning healthy coping skills, more useful communication skills, and more functional behaviors, through my teaching, encouraging, and modeling necessary behaviors. In the therapeutic process we will use various techniques including, but not limited to: psychodrama, family sculpting, role playing, parts party, ingredients of an interaction, family reconstruction, genograms, mandala of the self, meditations, transforming family rules into guidelines, and critical impact reconstruction, bibliotherapy, and educational teaching. If counseling is successful, you will feel that you are able to face life's challenges in the future without my support or intervention.

Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or negotiate modification of any of my suggestions. At any time, either you or I may initiate discussion of possible positive or negative effects of entering or not entering counseling, continuing or not continuing counseling, and/or using or not using certain techniques. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you. I assure you that my services will be rendered in a professional manner, consistent with accepted ethical standards. While the course of therapy is designed to be helpful, it may at times be difficult or uncomfortable.

Sessions for individual clients are usually held weekly for about 45 minutes. Couple or family group sessions are held for 90 minutes. Although our sessions will be very intimate psychologically, *ours is a professional relationship rather than a social one*. Our contact will be limited to the counseling sessions that you arrange with me, except in case of emergency when you may contact the Center Street Counseling Services by phone. Please do not invite me to social gatherings, offer me gifts, ask for me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me in my professional role only.

Please see other side>

Fees and Cancellation

In return for an initial intake fee of $150.00, then $120.00 for an individual client's 45-minute session thereafter, I agree to provide counseling services for you. (A sliding scale fee schedule may be available, based on ability to pay.) Longer sessions and other services are pro-rated from the basic fee and are billed according to the time involved. Evaluative individual sessions are $150.00 each. ***The full fee* or *your insurance co-pay must be paid at the beginning of each session.*** Cash, credit cards, or personal checks are acceptable for payment. Insurance reimbursement may or may not be possible. Your insurance agreement is between you and your insurance company. It is the policy of this office to bill your credit card if your insurance company does not pay within 90 days of the date of service. ***Due to the limited number of appointments available—barring true life-threatening emergencies—missed appointments and late cancellations are charged at the above rate.*** A photocopy of your driver's license, insurance card, and a major credit card is required. The credit card will only be used for unpaid charges.

You are responsible for the full counseling fee, regardless of whether or not these services are covered by your insurance. __________ *(initial)*

Health insurance companies often require that I diagnose your emotional condition before they agree to reimburse you. *Any diagnosis made will become a part of your permanent insurance records*. __________ *(initial)*

In the event that you will not be able to keep an appointment, you must notify the counseling services office at least ***24 hours*** in advance. For **Monday appointments**, notification must be given no later than the previous Thursday. ***If you do not provide such advance notice, you will be responsible for paying in full–per the above fee schedule–for the missed session.*** __________ *(initial)*

Referrals

Should you and/or I believe that a referral is needed, I will provide some possible referral sources. A verbal exploration of alternatives to counseling will also be made available upon request. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaint to the Texas State Board of Examiners of Professional Counselors at: (512) 834-6658.

Records and Confidentiality

Our communication becomes part of the clinical record. I will keep confidential anything that you say to me, *with the following exceptions*: a) If I believe that you are a danger to yourself or others; b) If I am ordered by a court to disclose information; c) If you disclose information concerning physical or sexual abuse to a minor or an elderly or disabled person; d) If you disclose sexual contact with another health professional; or e) If you direct me to tell someone else. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. __________ *(initial)*

By your signature below, you are indicating that you have read and understood this statement, and that any questions about this statement have been answered to your satisfaction.

Client Signature: ______________________________

Client/Guardian Signature: ______________________

Date: ______________________________________

Counselor Signature: Kit Jones L.P.C.

Date: ______________________________________

KIT JONES, M.ED., L.P.C.

2308 RYAN PLACE DRIVE, FORT WORTH, TEXAS 76110—PHONE: (817) 921-0433 —WEBSITE: WWW. KITJONESLPC.COM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices as a requirement under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Although KIT JONES, M.ED. has always had privacy and patient confidentiality standards in place to limit unauthorized access or disclosure of personal health information, the new privacy rule provides additional safeguards for ensuring that health information is adequately protected and is used to provide quality patient care.

The Notice explains how KIT JONES, M.ED., L.P.C. may use and share your personal health information to carry out treatment, payment of services and health care operations. Other reasons permitted or required by law are also referred to in the notice. The notice explains your rights to read and control your protected health information and explains the responsibility KIT JONES, M.ED., L.P.C. has to protect you.

Personal health information may be about your past, present, or future physical or mental health or condition related to health care services. It could include your age, ethnicity, or other personal statistics. You have the right to do the following.

- Read and copy your personal health information,
- Ask for limits to be put on the use or sharing of your health information,
- Ask for privacy protections when communication of your personal health information is done,
- Ask to have corrections made to your personal health information, and
- Get a listing of where and when your personal health information was shared.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Following are examples of permitted uses and disclosure of your protected health information. These examples are not exhaustive:

Required Uses and Disclosures

By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health with a third party. We may disclose your protected health information from time to time to another physician, or health care provider who, at the request of your physician, becomes involved in your care by providing assistance with your diagnosis or treatment. This includes pharmacists who may be provided information on other drugs you have been prescribed to identify potential interactions. In emergencies, we will use and disclose your protected health information to provide the treatment required.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
NOTICE OF PRIVACY PRACTICES

Payment

Your protected health information will be used to obtain payment for your health care services. This may include certain activities that KIT JONES, M.ED., L.P.C. might undertake that may need insurance approval before insurance will pay (reviewing services provide to determine medical necessity.)

Health Care Operations

KIT JONES, M.ED., L.P.C. may use or disclose your protected health information to support the daily activities related to health care. These activities include, but are not limited to, quality assessment activities, investigations, training of students, and conducting or arranging for other health care related activities.

Public Health

We may disclose your protected health information to a public health authority that is permitted by law to collect or receive the information. The disclosure may be necessary to do the following:

- Prevent or control disease, injury, or disability,
- Report child abuse or neglect,
- Report reactions to medications or problems with products,
- Notify a person who may have been exposed to or may be at risk for contracting a disease,
- Notify the appropriate government authority if we believe a patient is the victim of abuse, neglect, or domestic violence as required by law.

Communicable Diseases

KIT JONES, M.ED., L.P.C. may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk for contracting or spreading the disease or condition.

Food and Drug Administration

KIT JONES, M.ED., L.P.C. may disclose your protected health information to a person or company required by the Food and Drug Administration to do the following:

- Report adverse events, product defects, or problems and biologic product deviations.
- Track products.
- Enable product recalls.
- Make repairs or replacements.
- Conduct post-marketing surveillance as required

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
NOTICE OF PRIVACY PRACTICES

Legal Proceedings

KIT JONES, M.ED., L.P.C. may disclose protected health information during any judicial or administrative proceeding, in response to a court order and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement

KIT JONES, M.ED., L.P.C. may disclose protected health information for law enforcement purposes, including the following:

- Responses to legal proceedings
- Information requests for identification and location
- Circumstances pertaining to victims of a crime
- Deaths suspected from criminal conduct
- Crimes occurring at KIT JONES, M.ED., L.P.C. offices
- Medical emergencies

Coroners, Funeral Directors, and Organ Donations

KIT JONES, M.ED., L.P.C. may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law.

Research

KIT JONES, M.ED., L.P.C. may disclose your protected health information to researchers when authorized by law, for example, if their research has been approved by an institution review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

By your signature below, you are indicating that you have read and understood this statement, and that any questions about this statement have been answered to your satisfaction.

{Client Signature: ________________________________

{Date: ____________________________________

KIT JONES, M.ED., L.P.C.

In an effort to reduce administrative costs and thus allow us to continue directly billing your insurance company, a new office policy is being adopted. In addition to annually photocopying your insurance card and driver's license, an image of a major credit or debit card is now required. This credit/debit card will only be used for unpaid charges.

If you should feel uncomfortable with this policy, we understand and will allow you to work with your insurance company directly. This will require you to pay in full for our services as they are rendered.

SIGNATURE ON FILE

(√) I authorize the use of this form on all insurance claims.

(√) I authorize the release of information to my insurance company.

(√) I am responsible for my bill.

(√) I authorize the above provider to act as my agent to help me obtain payment from my insurance company.

(√) I authorize payment to be made directly to the above provider of services.

(√) I allow a copy of this authorization to be used in place of the original.

(√) I authorize the use of my credit/debit card for unpaid charges. Missed appointments and late cancellations will be charged.

By your signature below, you are indicating that you have read and understood this statement, and that any questions about this statement have been answered to your satisfaction.

Client Signature: ____________________________________

Date: ____

KIT JONES, M.ED., L.P.C.

2308 RYAN PLACE DRIVE, FORT WORTH, TEXAS 76110-2545—PHONE: 817/921-0433—WEBSITE:WWW.KITJONESLPC.COM

KIT JONES, M.Ed., L.P.C.

CLIENT NAME ______________________
Date ______________________

Life Status Questionnaire

Please read carefully and follow instructions below.

Please complete all of the questions. Do not skip any of the questions.
Please answer each question as it applies to you only during the last seven (7) days.
For this questionnaire, work is defined as employment, school, volunteer work, housework, and so forth.
Only **fill in** one (1) answer per item. Please do **NOT** use a checkmark or an "x".

Shade Circles Like This > ●

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I have trouble falling asleep or staying asleep	○ 0	○ 1	○ 2	○ 3	○ 4
2. I feel no interest in things	○ 0	○ 1	○ 2	○ 3	○ 4
3. I feel stressed at work, school or other daily activities	○ 0	○ 1	○ 2	○ 3	○ 4
4. I blame myself for things	○ 0	○ 1	○ 2	○ 3	○ 4
5. I am satisfied with my life	○ 4	○ 3	○ 2	○ 1	○ 0
6. I feel irritated	○ 0	○ 1	○ 2	○ 3	○ 4
7. I have thoughts of ending my life	○ 0	○ 1	○ 2	○ 3	○ 4
8. I feel weak	○ 0	○ 1	○ 2	○ 3	○ 4
9. I find my work/school or other daily activities satisfying	○ 4	○ 3	○ 2	○ 1	○ 0
10. I feel fearful	○ 0	○ 1	○ 2	○ 3	○ 4
11. I use alcohol or a drug to get going in the morning	○ 0	○ 1	○ 2	○ 3	○ 4
12. I feel worthless	○ 0	○ 1	○ 2	○ 3	○ 4
13. I am concerned about family troubles	○ 0	○ 1	○ 2	○ 3	○ 4
14. I feel lonely	○ 0	○ 1	○ 2	○ 3	○ 4
15. I have frequent arguments	○ 0	○ 1	○ 2	○ 3	○ 4
16. I have difficulty concentrating	○ 0	○ 1	○ 2	○ 3	○ 4
17. I feel hopeless about the future	○ 0	○ 1	○ 2	○ 3	○ 4
18. I am a happy person	○ 4	○ 3	○ 2	○ 1	○ 0
19. Disturbing thoughts come into my mind that I cannot get rid of	○ 0	○ 1	○ 2	○ 3	○ 4
20. People criticize my drinking (or drug use) (If not applicable, mark "never")	○ 0	○ 1	○ 2	○ 3	○ 4
21. I have an upset stomach	○ 0	○ 1	○ 2	○ 3	○ 4
22. I am not working/studying as well as I used to	○ 0	○ 1	○ 2	○ 3	○ 4
23. I have trouble getting along with friends and close acquaintances	○ 0	○ 1	○ 2	○ 3	○ 4
24. I have trouble at work/school or other daily activities because of drinking or drug use (If not applicable, mark "never")	○ 0	○ 1	○ 2	○ 3	○ 4
25. I feel that something bad is going to happen	○ 0	○ 1	○ 2	○ 3	○ 4
26. I feel nervous	○ 0	○ 1	○ 2	○ 3	○ 4
27. I feel that I am not doing well at work/school or in other daily activities	○ 0	○ 1	○ 2	○ 3	○ 4
28. I feel something is wrong with my mind	○ 0	○ 1	○ 2	○ 3	○ 4
29. I feel blue	○ 0	○ 1	○ 2	○ 3	○ 4
30. I am satisfied with my relationships with others	○ 4	○ 3	○ 2	○ 1	○ 0

Developed by Gary M. Burlingame, Ph.D., Michael J. Lambert, Ph.D., Curtis W. Reisinger, Ph.D. and PBH, Inc.