



Sammie Jones, MA, LPC  
Seek Balance

Houston Psychotherapists, Inc.  
832-237-2673

[www.houstonpsychotherapists.com](http://www.houstonpsychotherapists.com)

### CONFIDENTIAL INFORMATION SHEET

Please fill out this questionnaire as completely as possible. Print all information clearly. All information provided is confidential.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### PATIENT INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Preferred:  Home  Work  Cell May we leave you messages:  Yes  No Best # to leave message: H W C

Email: \_\_\_\_\_ May we email you:  Yes  No

Sex:  Female  Male Marital status:  Married  Single  Widowed  Divorced  Domestic Partner

Please thank \_\_\_\_\_ for referring me.  Yes  No

Reason for referral / visit: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### INSURANCE INFORMATION

Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to Client: Self  Spouse  Parent  Child  Other  Please describe: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Legal guardian of minor patient: \_\_\_\_\_

Signature confirms consent to treat of minor

### FINANCIAL AGREEMENT

My signature below indicates that:

- I agree to accept all financial responsibility for payment of all fees at the time of my visit, unless other arrangements have been agreed to with my individual clinician.
- I authorize the release of any information required by the insurance provider to process insurance claims for reimbursement of services.
- I authorize the payment of insurance benefits from my insurance company directly to the provider.
- I understand this financial agreement and guarantee the accuracy of the information provided on this form. I understand it is my responsibility to notify this office of any changes to the information I have provided.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

## POLICIES AND PROCEDURES

**Fees and Payment:** Payment for services is expected at the time of your session. Checks and cash are the preferred form of payment. For your convenience we also accept credit cards. The client is responsible for all fees or portion of fees not covered by health insurance. Additional costs may be incurred for copies of medical records or report writing for agencies or another professional. If for any reason a client is unable to pay at the time of service or a balance is accrued, payment arrangements can be discussed with your clinician.

**Cancellations:** Cancellations made with less than 24 hours notice will be charged at ½ the full session rate of \$140.00, unless there are extenuating circumstances. If you must cancel an appointment, call the office at 832-237-2673. For your convenience a message can be left at this number 24 hours a day, 7 days a week. Please note that insurance does not cover missed appointments or appointments cancelled without sufficient notice. The client will be solely responsible for the fee.

**Length of Session:** Sessions are scheduled for 50 minutes. I understand your time is valuable and I work very hard to stay on schedule but ask your understanding that, given the nature of therapy, there are times when appointments may last longer. If this happens, please be assured that when necessary you will be afforded the same consideration. If your appointment begins late, I will make every effort to ensure that you will receive a full 50 minute session.

**Confidentiality:** All information shared in the therapy session and all written documents pertaining to the session are confidential and protected by federal law. Exceptions include imminent danger to yourself or someone else, testimony required by a judge, or consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identifying information. Release of information to other professionals requires your written consent.

**Client Privacy:** It is important to understand that emails and mobile phone conversations are not guaranteed secure or private because they could be intercepted. Therefore, by signing this document you understand that if we have correspondence by email or mobile phone, it is possible for confidentiality to be compromised. Additionally, information shared in a group environment cannot be guaranteed to remain confidential, though all group members are asked to protect the confidentiality of each member.

**Telephone and Emergency Procedures:** *In the case of a life and death emergency, dial 911 or proceed to the nearest emergency room.* Our office phone is equipped with an answering machine that allows you to leave messages. I check messages periodically throughout the day and make every attempt to return calls in a timely manner. However, if you leave a message, and do not receive a return call within 24 hours, please call again. If during our work together I become concerned about your safety or the safety of someone else, I will take reasonable actions, afforded by the law, to ensure your own and others' safety. If possible, I will always discuss such measures with you in advance and empower you to assist me in making the best decision for implementing effective safety measures.

**Psychotherapy:** Participation in psychotherapy offers many benefits. To get the most out of therapy it is important to take responsibility for your active participation in the therapeutic process. By providing honest and complete information, I am better able to understand your problems and what approach will be most helpful in accomplishing your goals and assisting you in changing your thoughts, feelings and/or behaviors. Many times it is difficult to discuss painful or sensitive topics. Exploring, evaluating and challenging thoughts, long held assumptions/perceptions, and past experiences can evoke feelings of sadness, fear, anger and emotional discomfort. Loved ones close to you may experience distress as you implement changes through the counseling process. Things may appear to become worse before getting better. Regular, consistent participation in therapy and completing assignments between sessions (as agreed upon with your therapist) will facilitate the process and increase the likelihood of achieving your treatment goals. However, no therapist can ethically guarantee the results of participation in psychotherapy. Additionally, no single therapist is the best one for every client. If you feel you are not obtaining the results you had hoped for in therapy or would like to discontinue treatment, we encourage you to talk to your therapist about your concerns. If you do not feel your therapist is a good fit, we will be happy to provide you with a referral to another clinician in our clinic or at another office. You are free to discontinue therapy at any time and closure is an important part of the therapeutic process.

- ☉ *I understand and agree to the above policies and procedures.*
- ☉ *I have been given the opportunity to ask questions and verbalize any concerns regarding these policies and the limitations of therapy.*
- ☉ *My signature below confirms my informed consent to psychotherapy treatment.*
- ☉ *I understand and agree to the policies concerning both payment and cancellation of appointments.*

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Signature of Patient or Responsible Party

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Date

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA), I have certain riehts to privacy regarding my protected health information. I understand that this information can and will be used to:

- ☉ Conduct, plan and direct my treatment and follow up with other healthcare providers who may be involved in that treatment directly and indirectly.
- ☉ Obtain payment from third party payers.
- ☉ Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Houston Psychotherapists, Inc. has the right to change its Notice of Privacy Practices and that I may contact the office at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requests, but it you do agree then you are bound to abide by such restrictions.

\_\_\_\_\_  
Patient Name or Responsible Party

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

Reason: \_\_\_\_\_

**PRE-AUTHORIZED CHARGE FORM**

I authorize Houston Psychotherapists, Inc. to keep my signature on file and charge my credit card listed below for:

- Balance of charges not paid by insurance within 90 days.
- ½ of the full session fee of \$140.00 for missed appointments and late cancellations. A total of **\$70.00** \_\_\_\_\_ (initials) will be charged to my card. Please be advised that insurance companies will not reimburse your clinician for a missed appointment or one cancelled with less than 24 hours notice.

I understand this authorization is valid for one year. I can revoke this authorization at any time by providing a written request to my provider.

Patient Name: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Card Type:

- Visa
- MasterCard
- Discover
- American Express

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Card Verification Number: \_\_\_\_\_ Billing Address Zip Code: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

Date: \_\_\_\_\_