Client Information Form

Name ____ Date ____________

Address ____

City ___________________________ State _________________ Zip Code _____

Home Ph ____________________ Work Ph _______________ Cell Ph ________________

Can messages be left at these numbers? Y ☐ N ☐ If no, how best can you be reached?________________

Email ____

May we contact you by email, if necessary? Y ☐ N ☐

Birthdate ________ Age ______ Social Security Number ______________ Gender M ☐ F ☐

Marital Status M ☐ S ☐ W ☐ D ☐ Spouse or Partner's Name ______________ Years together ______

How were you referred? ____

Family Medical Doctor (first and last name, phone)________________________________

Psychiatrist (first and last name, phone) ______________________________________

Other Medical Providers (first and last name, phone) ______________________________

Emergency Contact Person	Relation	Home Phone	Work Phone	Cell Phone
1.				
2.				
3.				

Party responsible for payments

Name ______________________________________ Relation __________________

Address ____

City ______________________________ State ________________ Zip Code _________

Phone Number ____________________ Fax ___________________

Credit Card information

I, ___________________________, authorize Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW to process the listed credit card for payment for counseling, counseling related services, consulting, fees for no shows, and failure to provide 24-hour notice for cancelation.

This credit card will be billed within 48 hours of service or the occurrence of a no show or same-day cancelation unless another form of payment is provided.

Type of Credit Card: ☐ **Visa** ☐ **Master Card** ☐ **Discover** ☐ **American Express**

Name on the Card ____

Credit Card Number ____

Expiration Date _______________ 3 or 4 Digit Security Code ____________

Billing Address ____

City ______________________ State _________ Zip ___________

I agree that the above information is true and I understand that my card will be charged and I will be responsible for the fees.

____ ______________________
Signature Date

____
Printed Name

Insurance

Waiver of insurance benefits: I am aware that Rob Novick, LCSW is in-network with select insurance plans, disclosed prior to initial appointment. However, I am choosing to not use in-network benefits and agree not to request reimbursement from my insurance provider. I have been informed that I will receive a basic receipt stating payment for services, at my request, which will not include required information for insurance reimbursement. I acknowledge that I am responsible for the private pay rate. Insurance information is not required, if signing waiver below. If I rescind this waiver, I will provide in writing, my insurance information, and can only use my insurance benefits for services after I provide this information. I understand that no services provided prior to rescinding this waiver will be covered by insurance.

____
Signature to waive insurance

Insurance Company ____________________________ Subscriber Name ____________________________

Policy Number: ____________________________ Group Number: ____________________________

Phone Number: ____________________________ Address: ____________________________

Additional Information

Reason for requesting assistance ____

____

____

Any specific questions you want to ask during first session? ____

____

____

What goals would you like to accomplish?____

____

____

My symptoms include (Check all that apply):

☐	Depression	☐	Feeling hopeless	☐	Sadness
☐	Anxiety/Worry too much	☐	Feeling helpless	☐	No pleasure in activities
☐	Trouble sleeping	☐	Crying spells	☐	Unintentional weight change (up/down)
☐	Sleeping too much	☐	Poor attention	☐	Can’t sit still
☐	Suicidal Thoughts	☐	Poor memory	☐	Can’t work
☐	Thoughts to harm others	☐	Poor concentration	☐	Troubling thoughts
☐	No energy	☐	Confused	☐	Pain
☐	Too much energy	☐	Can’t eat	☐	Alcohol/Drug abuse (currently or in past)
☐	Feelings of worthlessness	☐	Eating too much	☐	Feeling paranoid

Additional symptoms that are not mentioned____

____

What medications are you taking, including PRN (as needed)? (Name and dosage) ____________________________

____

____

Medical problems/issues ____

____

Past counseling, psychiatric hospitalizations and chemical dependency treatment and dates ______________________

____

____

FEES, CANCELLATION, AND OFFICE POLICIES

CONFIDENTIALITY: You are protected by the confidentiality laws in Texas, which state that anything discussed during our sessions and meetings is privileged information and cannot be shared with anyone else without your prior consent. This also means that we cannot tell anyone whether you are receiving assistance by Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW without your permission.

Possible exceptions to confidentiality include those provided by law, including but not limited to: child abuse; abuse, neglect or exploitation of the elderly or the disabled; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; or situations where Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW has a duty to disclose.

FEES: Sessions are 50 minutes in length. The fee for a session is $180. Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW does accept some insurance and Medicare. For insurance plans that are out of network, the full session rate must be paid by the client and a Superbill will be provided for insurance reimbursement to the client. Clients are responsible for the payment of all charges regardless of insurance benefits. An additional 4% will be added to any charge when using a credit card.

To cancel an appointment, call the office at least 24-business hours prior to your appointment. Any cancelation where at least 24-hour notice is not given by phone, the full session fee is charged. Insurance will not reimburse when the insured is not present.

If failure to attend two consecutive sessions without 24 hours' notice, or if consistently canceling appointments, the behavior could result in termination of the services.

Telephone consultations need to be scheduled in advance. There is no charge for occasional, brief, telephone calls. However, extended calls and telephone consultations will be charged at the rate intervals of 15 minutes and the cost of $40 for each 15 minutes.

OTHER FEES: A $25.00 fee is assessed for each set of forms requested by the client to be completed by the clinician.

There is a $30.00 fee to process returned checks, payable prior to next scheduled session.

In the event law requires disclosure of records or therapist testimony, client will be responsible for and shall pay the cost involved in producing those records at $1.00 per page ($25.00 minimum - payable in advance). The therapist will be paid $300.00 per hour (minimum 8 hours - payable in advance) for the time involved in preparing for legal proceedings. Additional fees for testimony and travel time will be provided upon request.

TELEPHONES: Phones are answered from 9:00AM until 5:00PM Monday through Friday. Please use the voice mail system to handle all calls during and outside of stated hours. Please leave your name, phone number, best time to reach you, and the purpose of the call. All calls will be returned as soon as possible. In case of an emergency, be sure to call 9-1-1, when appropriate.

OTHER POLICIES: To ensure confidentiality and the integrity of the therapeutic relationship, do not attempt to "friend" or contact Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW or any of his associates through social media websites, such as Facebook, Twitter, LinkedIn, or any other site. Emails and texts are not considered confidential means of communication, so please use these methods for non-emergent, non-clinical matters only.

CONSENT TO TREATMENT: I, voluntarily, agree to receive or authorize an assessment, treatment or services, and care (if receiving counseling), and authorize Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of the care, treatment or services, and that I may stop such care, treatment or services that are provided by Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW.

TELEMENTAL HEALTH INFORMED CONSENT: I consent to Telemental Health, if we mutually determine that it is an appropriate means to communicate. I understand that Telemental Health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW utilizes Doxy.Me. This internet platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.Me is willing to attest to HIPAA compliance and assumes responsibility for keeping our live video interaction secure and confidential. If we choose to utilize this technology, Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW will give you detailed directions regarding how to log-in securely. Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW also asks that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW strongly suggests that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

I understand the following with respect to Telemental Health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risk and consequences associated with Telemental Health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telemental Health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telemental Health services are not appropriate and a higher level of care is required.

6) I understand that during a Telemental Health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 214-586-0066 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: ____

and my emergency contact person's name, address, phone: __________________________________

____

I give permission for Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW to call and leave messages at my home or place of business or location I provide. I also give permission for letters, bills, etc., to be mailed to my home or designated address.

By my signature below, I, the undersigned client or authorized agent, acknowledge that I have both read and understand all the terms and information in this form, including fees and conditions for payment. I acknowledge that I have been given enough time to ask questions about this agreement and agree to abide by policies set forth in this agreement.

NOTICE OF PRIVACY POLICY: I acknowledge that I have received a copy of the HIPAA Notice of Privacy Policy for Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information in this packet and have completed the above answers. I will notify Full Circle Counseling & Consulting, PLLC/Rob Novick, LCSW of any changes in my status or the above information.

By my signature below, I, the undersigned client or authorized agent, acknowledge all of the information on this Client Information Form is accurate to the best of my knowledge.

____ ________________________

Signature of client or authorized representative Date

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle the best answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ____________ ____________ ____________ ____________

Total Score: ____________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Please circle the answer)

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

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GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle the best answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

FOR OFFICE CODING ___________ ___________ ___________ ___________

Total Score: ___________

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