The Woodlands Family Counseling Center
33300 Egypt Lane Suite I-200
Magnolia, TX 77354
(936) 463-8185

ADULT REGISTRATION DATE: _____

FIRST NAME	MIDDLE NAME	LAST NAME
ADDRESS		
CITY/STATE/ZIP		DATE OF BIRTH
CELL PHONE	WORK/HOME PHONE	GENDER ☐ FEMALE ☐ MALE
EMAIL ADDRESS:		
EMPLOYER		JOB TITLE
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED		
SPOUSE NAME	DATE OF BIRTH	CELL PHONE #
EMERGENCY CONTACT		
NAME	PHONE	RELATIONSHIP
RESPONSIBLE PARTY (If different than client)		
BILLING FULL NAME		RELATIONSHIP TO CLIENT
BILLING PHONE		
BILLING ADDRESS		CITY/STATE/ZIP

Welcome to The Woodlands Family Counseling Center. We are pleased that you have selected our family and we look forward to helping your family. **Please carefully read the information below and initial next to each section indicating you understand the information provided.**

CONSENT FOR TREATMENT	
Initial Here	Informed consent is a document that describes the treatment processes, policies and procedures, fee structures, client and therapist responsibilities, and numerous other topics involved in the counseling process. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with your therapist or group leader is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of therapy at any time.
OTHER FEES	
_____	Preparation of summaries of treatment or letters (i.e. for medical doctors or schools) at request of client will be billed at $150 per item requested.
PAYMENT FOR MINORS	
Initial Here	Parents or guardians accompanying minors are responsible for payment of co-pays or balances at the time of service. If a minor is accompanied by an adult other than a parent or guardian, payment is still expected at the time of service. For unaccompanied minors, charges MUST be pre-authorized to an approved credit card, or paid by cash or check prior to, or at the time of service.
LITIGATION LIMITATION	
Initial Here	TWFCC does NOT provide disability determination, custody studies, or handle court issues. It is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records by requested. ➢ TWFCC providers do not perform court evaluations nor do they appear in court on behalf of individuals, children or adults. TWFCC services are designed to assist in alleviating problems through individual or relational psychotherapy. TWFCC providers are not trained for, nor do they maintain records with the intended purpose of court involvement. ➢ In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition. ➢ However, should your therapist opinion be so ordered, fees will be charged at the rate of $300 per hour, portal to portal (meaning this includes, but is not limited to, all time

	involved for preparation, parking, mileage, travel time to and from court, and all other expenses involved in testifying). This fee will apply as well to depositions or interrogatories. Records review, consultation with clients, litigants, attorneys (in person, via phone or by email), reports, waiting at court or any other service provided will be charged at the rate of $175 per hour or prorated accordingly. These fees are payable in advance. ➢ The client further agrees to pay a retainer fee of $1,250.00 two weeks prior to the appearance, presentation of records, or testimony requested.
CONFIDENTIALITY AND RECORDS	
Initial Here	The information you share with your counselor both written and verbally is part of your Protected Health Information (PHI) and is considered confidential. If the client is a minor, it is the legal right of the parents to have access to the information we discuss in our sessions. Detailed information regarding PHI and limitations of confidentiality are located in the Privacy Notice. There are some exceptions to confidentiality in which therapists are legally required to take protective action and to reveal information about a client. Those include: ➢ Allegations of sexual abuse, physical abuse, or neglect of a child, disabled person, or someone who is vulnerable and unable to leave the place of abuse due to institutionalization. Texas Law requires that all allegations of abuse be reported to law enforcement or the Department of Family and Children Services in the county where the client lives. ➢ A situation where a client poses a danger to self or others. ➢ Counselors are bound by the Duty to Warn when a client has made threats of violence toward a third party or when a third party has made threats of violence toward the client. ➢ When a judge orders that information be disclosed. We cannot guarantee that an appeal will be upheld, but we will do everything in my power not to disclose your confidential information.
UNATTENDED CHILDREN	
Initial Here	We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safety if left unattended. For the safety and welfare of the children and out of consideration for others, please make arrangements for childcare during therapy sessions, or provide adult supervision for children while waiting in the waiting room.
IN CASE OF EMERGENCY	
	Your therapist is not available for after-hours crisis or emergency situations. If you are in crisis and it is after hours, please call 911 or your nearest emergency room. You can also call the Tri-County 24-Hour Crisis Line: 1.800.659.6994.
TELEPHONE & EMAIL COMMUNICATION	
	Though email and text messages are quick and very convenient, we can never guarantee your confidentiality when using these modes of communications. We do NOT conduct therapy

Initial Here	over phone, email, or text. If you have an issue or problem you would like to discuss, please let us know by calling our office. If your counselor/therapist is not available, you can leave a message with our administrative assistant or leave a confidential voicemail. Messages will be returned as soon as possible during business hours. Please do not rely on your therapist's voicemail in times of crisis or for an emergency. Email and text should ONLY be used for scheduling purposes and may not be checked on a daily basis. *Please do not cancel appointments by email. You must call the office directly at (936) 463-8185*.
EFFECTS OF COUNSELING	
Initial Here	Therapy is the process of solving emotional problems by talking with a professional trained to help you achieve a more fulfilling individual life, marital/couple relationship, or family relationships. The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings, understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others. Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and your therapist are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.

ACKNOWLEDGEMENT

I hereby voluntarily consent to mental health counseling by my counselor. I have relied on my counselor for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. My signature below indicates that I have been provided a copy of, and that I fully understand & agree to all of the terms and conditions of the Counseling Policies. If you have any questions regarding anything on this form, please discuss them with your counselor before signing. This form has been fully explained to me, and I certify that I understand its contents. I also acknowledge that I have received a copy of the Notice of Policies and Practices to Protect the Privacy Healthcare Information (HIPAA).

CLIENT NAME: _____ DOB: _____

SIGNATURE OF CLIENT: _____ DATE: _____

INSURANCE INFORMATION (Not required for self-pay clients)

TWFCC is happy to submit claims on your behalf to the insurance company. However please read the below disclaimers. TWFCC reserves the right to bill any denied or unpaid claims to the credit card that has been provided and saved on file.

Insurance Disclaimer:

- "A quote of benefits, eligibility, and/or authorization does not guarantee payment. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

- Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made, by our office, to verify that your counseling services are verified and preauthorized with your health insurance company. If your health insurance company later determines that a particular service is not reasonable and necessary, or that a particular service is not covered under your plan, your insurer may/will deny payment for that service.

Beneficiary Agreement:

- I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. I understand and give TWFCC authorization to bill the credit card provided for any denied or unpaid portion of rendered services.

NAME OF INSURANCE COMPANY	SUBSCRIBER ID
NAME:	DOB:
GROUP ID	INSURANCE PHONE #

My signature below indicates that I have received a copy and read the above insurance disclaimer.

I authorize The Woodlands Family Counseling Center to disclose diagnostic information to (INSURANCE COMPANY) _____.

This disclosure of information authorized herein is required to verify insurance benefits. Such disclosure shall be limited to diagnostic information. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and if not revoked this consent shall continue from the date signed without express revocation.

SIGNATURE OF CLIENT	DATE

MISSED APPOINTMENTS AND CANCELLATIONS POLICY

I understand that The Woodlands Family Counseling Center's cancellation policy requires 24 hours advanced notice in order to cancel a session without penalty. Should I cancel within 24 hours of a scheduled appointment or not show up for a scheduled appointment, I hereby authorize The Woodlands Family Counseling Center to charge my credit card my full fee to cover my therapist's professional time.

I have read and understand the above credit card policy for services provided by The Woodlands Family Counseling Center.

CARD HOLDER NAME		
CARD NUMBER		
EXPIRATION DATE	CVW CODE	BILLING ZIP CODE
CARD HOLDER SIGNATURE	DATE	

PRIMARY REASON(S) FOR SEEKING SERVICES (PLEASE CHECK ALL THAT APPLY):

___ Marital Problems	___ Relationship	___ Parenting
___ Family	___ Anxiety	___ Depression
___ Coping skills	___ Anger management	___ ADHD
___ Eating disorder	___ Alcohol/Drugs	___ Addictive behaviors
___ Sleeping problems	___ Sexual concerns	___ Job
___ Health problems	___	

MARITAL STATUS (MORE THAN ONE ANSWER MAY APPLY)

Single	Divorce in process Length of time:_____	Divorced Length of time:_____
Legally married Length of time:_____	Unmarried, Living together Length of time:_____	Widowed Length of time:_____
Dating	Total number of marriages	

FAMILY & HOUSEHOLD INFORMATION (include spouse, housemates, and all children)

NAME	AGE	RELATIONSHIP	LIVING WITH YOU?
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

MEDICATIONS (Prescribed and Over-the-Counter)

MEDICATION	PURPOSE

MEDICAL / PHYSICAL HEALTH (PLEASE CHECK ALL THAT APPLY):

___ Alcoholism	___ Abortion	___ Anemia
___ Cancer	___ Chronic pain	___ Diabetes
___ Drug abuse	___ Eating problems	___ Fatigue
___ Headaches / Migraines	___ High blood pressure	___ Miscarriages
___ Nausea / Stomach aches	___ Sexual problems	___ Sleeping disorders
___ Sexual transmitted disease	___ Thyroid problems	___
___ Other (describe):		

LEGAL ISSUES

Are you involved in any criminal proceedings or litigation at the present time? _____ YES _____ NO

If yes, describe: _____

Are you presently on probation or parole? _____ YES _____ NO

If yes, describe: _____

PLEASE CHECK ANY EVENTS THAT HAVE OCCURRED IN THE LAST 12 MONTHS:

___ Birth of a child	___ Death of a loved one	___ Divorce
___ Financial problems	___ Marriage	___ Moving
___ Natural disaster	___ Other: _____	

BEHAVIORAL HISTORY (PLEASE CHECK ALL THAT APPLY):

___ ADHD	___ Aggression / Anger	___ Alcohol dependence
___ Anxiety	___ Cyber addiction	___ Depression
___ Drug dependence	___ Eating disorder	___ Fatigue
___ Gambling	___ Hopelessness	___ Impulsivity
___ Irritability	___ Judgment errors	___ Loneliness
___ Memory impairment	___ Mood shifts	___ Panic attacks
___ Phobia / Fears	___ Pornography	___ Spending problems
___ Sexual difficulties	___ Sleeping problems	___ Social problems
___ Suicidal thoughts	___ Withdrawing	___ Worrying

___ Other (describe):

Briefly discuss how the above symptoms impact your ability to function:

If yes, describe:

_____

_____

Does anyone in your family have a history of anxiety, depression, or other mental health problems?

If yes, describe: _____

_____

Where there special, unusual, or traumatic circumstances that affected you in childhood? (i.e., car accidents, domestic violence, trauma, abuse, significant loss)

If yes, describe: _____

_____

COUNSELING GOALS

In the first few sessions, we will work together to identify your goals for counseling and a plan to achieve them.

1) _____

_____

_____

2) _____

_____

_____

3) _____

_____

_____