NEW BEGINNINGS
PATIENT INFORMATION SHEET

DATE: _____ THERAPIST: _____

PATIENT INFORMATION

NAME_____DATE OF BIRTH_____

HOME ADDRESS_____CITY_____STATE____ZIP_____

MARITAL STATUS:____SINGLE ____MARRIED____ DIVORCED ____WIDOWED ____COHABIT ____OTHER

SOCIAL SECURITY NUMBER _____ _____M _____F

HOME # _____ CELL # _____

WORK # _____ _____EMAIL _____

CAN WE LEAVE A MESSAGE? _____YES _____NO

WHICH NUMBER DO YOU WANT US TO CALL ? _____

IN CASE OF EMERGENCY CALL: _____ _____TELEPHONE # _____

ADDRESS: _____

_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____DATE OF BIRTH_____M____F_____

HOME ADDRESS _____CITY _____STATE_____ZIP_____

INSURANCE COMPANY_____PHONE #_____

ID#_____SOCIAL SECURITY # _____

GROUP # _____EMPLOYER_____

_____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED _____DATE OF BIRTH _____M____F_____

HOME ADDRESS_____CITY _____STATE_____ZIP_____

INSURANCE COMPANY_____PHONE #_____

ID#_____SOCIAL SECURITY # _____

GROUP # _____EMPLOYER_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ASSIGN ALL BENENFITS TO THE PROVIDER. I UNDERSTAND THAT MISSED APPOINTMENTS WILL BE CHARGED UNLESS A 24 HR NOTICE IS GIVEN.

SIGNATURE_____DATE_____

NEW BEGINNINGS
PSYCHOSOCIAL ASSESSMENT

NAME: _____ DOB _____

BRIEFLY DESCRIBE YOUR REASON FOR SEEKING COUNSELING AT THIS TIME:

_____

_____

HOW LONG HAS THIS PROBLEM BEEN A CONCERN TO YOU? _____

WHEN WAS THE PROBLEM FIRST NOTICED? _____

CHECK THE CURRENT STRESSORS THAT APPLY TO YOUR LIFE: _____

___MARRIAGE ___WORK___SCHOOL___CHILDREN___FINANCES___PARENTS___HEALTH___OTHER

CHECK THE ITEMS BELOW THAT DESCRIBE YOUR CURRENT SYMPTOMS:

___APPETITE DISTURBANCE	___DIFFICULTY CONCENTRATING	___CRYING SPELLS
___SLEEP PROBLEMS	___ANXIETY	___ISOLATION
___IRRITABILITY	___SUICIDAL THOUGHTS/PLANS	___WORK/SCHOOL ABSENCE
___MOODINESS	___HOMICIDAL THOUGHTS/PLANS	___AGGRESSIVESNESS
___MEMORY IMPAIRMENT	___HALLUCINATIONS	___POOR IMPLUSE CONTROL
___WEIGHT GAIN/LOSS	___CUT/BURN ON SELF	___DOMESTIC VIOLENCE
___FEELINGS OF SADNESS	___SUICIDAL ATTEMPTS	___SEXUAL ABUSE
___SELF ABUSE	___SEXUAL ISSUES	___ROAD RAGE

HAVE YOU RECEIVED PRIOR COUNSELING PLEASE LIST WITH WHOM:_____

WAS THE COUSELING HELPFUL? WHY OR WHY NOT: _____

HAS ANYONE IN THE FAMILY RECEIVED COUNSELING OR PSYCHIATRIC SERVICES?_____

_____

NOTES: (FOR CLINICAL USE ONLY)

WHERE WERE YOU BORN? _____WHERE DID YOU GROW UP ?_____

WHAT ARE YOUR PARENT'S NAMES AND AGES?

MOTHER: _____ AGE: _____

FATHER: _____AGE: _____

ARE YOUR PARENTS:

____MARRIED

____DIVORCED: WHEN DID IT OCCUR? _____

____WIDOWED: WHEN DID IT OCCUR? _____

NEW BEGINNINGS
PSYCHOSOCIAL ASSESSMENT

BRIEFLY DISCRIBE WHO RAISED YOU: _____

PLEASE LIST THE NAMES OF ALL YOUR SIBLINGS:

_____ AGE: _____ _____ AGE: _____
_____ AGE: _____ _____ AGE: _____
_____ AGE: _____ _____ AGE: _____
_____ AGE: _____ _____ AGE: _____

NOTES (FOR CLINICAL USE ONLY)

IF MARRIED PLEASE ANSWER THE FOLLOWING:

NAME OF SPOUSE: _____ AGE: _____

HOW LONG HAVE YOU BEEN MARRIED? _____

PLEASE LIST THE NAMES AND AGES OF YOUR CHILDREN:

_____ AGE: _____ _____ AGE: _____
_____ AGE: _____ _____ AGE: _____
_____ AGE: _____ _____ AGE: _____
_____ AGE: _____ _____ AGE: _____

IF YOU HAVE EVER BEEN DIVORCED PLEASE ANSWER THE FOLLOWING:

NAME OF EX-SPOUSE _____ YEAR DIVORCE OCCURED: _____

NAME OF EX-SPOUSE _____ YEAR DIVORCE OCCURED: _____

DO YOU HAVE ANY STEP CHILDREN?

_____ AGE: _____ _____ AGE: _____
_____ AGE: _____ _____ AGE: _____

IF YOU ARE WIDOWED PLEASE ANSWER THE FOLLOWING:

NAME OF SPOUSE: _____ AGE AT TIME OF DEATH: _____

HOW LONG WERE YOU MARRIED? _____ DATE SPOUSE DIED: _____

DESCRIBE CAUSE OF DEATH? _____

HOW DID THE DEATH AFFECT YOU? _____

NOTES: (FOR CLINICAL USE ONLY)

NEW BEGINNINGS
PSYCHOSOCIAL ASSESSMENT

HOW MUCH EDUCATION HAVE YOU COMPLETED? _____
WHAT SCHOOL ARE YOU ATTENDING? _____
WHAT GRADE ARE YOU IN? _____ WHAT IS YOUR CURRENT GRADE AVERAGE? _____
ARE YOU HAVING TROUBLE IN SCHOOL? _____
ARE YOU PRESENTLY EMPLOYED? ____YES ____NO
IF YES, WHERE ARE YOU EMPLOYED? _____
HOW LONG HAVE YOUR WORKED THERE? _____
LIST ANY PRIOR JOBS IN THE LAST THREE YEARS:

_____ _____
_____ _____
_____ _____

IF YOU ARE UNEMPLOYED, WHAT IS YOUR PRIMARY SOURCE OF INCOME?

_____

NOTES: (FOR CLINICAL USE ONLY)

IS THERE A HISTORY OF ALCOHOLISM/DRUG IN YOUR FAMILY? ____YES ____NO
IF YES, BRIEFLY EXPLAIN:

_____
_____
_____

DO YOU DRINK ALCOHOL? _____
DO YOU USE ILLEGAL DRUGS? _____
DO YOU MISUSE PRESCRIBED MEDICATIONS? _____
HAS ANY FORM OF SUBSTANCE ABUSE EVER CAUSED PROBLEMS IN YOUR LIFE?

_____
_____

NOTES: (FOR CLINICAL USE ONLY)

HOW WOULD YOU DESCRIBE YOUR CURRENT STATE OF HEALTH? _____
DO YOU HAVE ANY CHRONIC MEDICAL PROBLEMS? _____
WHO IS YOUR PRIMARY PHYSICIAN? _____
WHO IS YOUR PSYCHIASTRIST? _____

NEW BEGINNINGS
PSYCHOSOCIAL ASSESSMENT

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

_____ DOSAGE: _____
_____ DOSAGE: _____
_____ DOSAGE: _____
_____ DOSAGE: _____
_____ DOSAGE: _____

NOTES: (FOR CLINICAL USE ONLY)

DO YOU HAVE ANY CURRENT LEGAL INVOLVEMENT (PROBATION, PAROLE, CPS): PLEASE EXPLAIN:

_____

_____

HAVE YOU EVER BEEN PHYSICALLY OR SEXUALLY ABUSED? _____
HAVE YOU OR A MEMBER OF YOUR FAMILY EVER BEEN IN THE MILITARY? _____
ARE YOU INVOLVED IN ANY RELIGIOUS ACTIVITIES? _____
DESCRIBE BRIEFLY WHOM YOU TURN TO FOR SUPPORT? _____
WHAT DO YOU HOPE TO GAIN BY ATTENDING COUNSELING?

_____

_____

NOTES (FOR CLINICAL USE ONLY)

TREATMENT GOALS:

1.

2.

3.

_____

NEW BEGINNINGS

Individual, Marital, Group & Family Therapy
PH (361) 570-8900 FAX (361) 570-8903
1501 E. Mockingbird Suite 262
Victoria, Texas 77904

Enrique Tores, Jr. M.A., LPC, LMFT
Cheryl J. Green MSW, LCSW
Ginger Corn M.ED., LPC, RPT

Gail Spurgeon M.ED., LPC
Danna Harrison M.A., LPC

ATTENTION: All Clients, Prospective Clients

DATE: April 20, 2022

REASON: Office policies on: Confidentiality, Duty to Warn, Dual Relationships, Informed Consent Regarding Fees and Professional Consultation, Client Rights

Dear Client(s) or Prospective Clients of New Beginnings:

Our clinic would like to Thank You for choosing to use the services of New Beginnings. The clinicians at New Beginnings would like to inform you of various office policies, which we believe to be of paramount importance to the welfare of both clients and clinicians alike. These policies are outlined as follows:

CONFIDENTALITY: Communications between a clinician and client and the client's records are considered confidential. No clinician at New Beginnings will be allowed to disclose any communication or records of a client except as provided in Texas Civil Statutes Article 5561h.4. For records to be released by the clinic, a release form must be signed by the client or client's legal guardian if a minor. Records can also be released under court order.

DUTY TO WARN: A clinician shall take reasonable personal action to inform the responsible authorities and appropriate individuals in cases where a client's condition indicates a clear and imminent danger to the client or others.

DUAL RELATIONSHIPS: A clinician shall not under normal circumstances be involved in the counseling of the clinician's family members, intimate friends, close associates, or others whose welfare might be jeopardized by such dual relationship. In order to preserve clear boundaries between clinician and client, no clinician at New Beginnings shall engage in what may be perceived as social fraternization with their clients, or receive, send, or exchange gifts with clients.

INFORMED CONSENT REGARDING FEES: New Beginnings will inform prospective clients regarding fee arrangements for payments which might affect the client's decision to enter into the treatment relationship. The policy of New Beginnings is to collect payment for services rendered the day the service is provided unless other arrangements are made. All accounts must remain with balances that are current. Accounts that are not current may incur service interruption until the account balance is cleared (noncurrent accounts are usually those with unpaid balances of $100.00 or more on the patient accounting records). All insurance payments must be made at the time-of-service delivery. **There will be a charge of $125.00 for appointments not cancelled 24 hours in advance.**

CHILDREN IN WAITING AREAS: Due to serious safety concerns and the unavailability of our office staff to supervise children in the waiting areas, **children under the age of 12 cannot be allowed to remain unattended in any of the New Beginnings waiting areas and will not be allowed to wander the halls.** Please make appropriate childcare arrangements prior to your scheduled appointments. Your cooperation in this matter is greatly appreciated.

CLIENTS RIGHTS: You have the right to professional, ethical treatment regardless of sex, race, color, religion, national origin, disability, sexual orientation, or political affiliation. You have the right to a clear description of services, fees, and billing. You have the right to choose a clinician you believe can help you and to be referred for other assistance if your clinician is unable to help you. Any communication during counseling is confidential unless otherwise provided by law.

I have read and understood the aforementioned policies and was afforded the opportunity to discuss them with a representative of New Beginnings.

RECEIPT OF NEW BEGINNINGS OFFICE POLICY/NOTICE OF PRIVACY PRACTICES

I, _____ have read and understood the New Beginnings Office Policy Form.

Signature of Client: _____ Date: _____

_____ Patient has refused to sign New Beginnings Office Policy
_____ Patient has refused to accept copy of the New Beginnings Office Policy
_____ Patient has received copy of the New Beginnings Office Policy

Signature of Witness: _____ Date: _____

I, _____ have received and/or reviewed a copy of New Beginnings Clinic notice of privacy practices.

_____ _____
Signature of Client **Date**

_____ Patient has refused to accept a copy of the Notice of Privacy Practices Acknowledgement Form

_____ _____
Signature of Witness **Date**

NEW BEGINNINGS
Counseling Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $ 10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: ___

Telephone: _____

E-mail: _____

Address: _____

New Beginnings
1501 E Mockingbird Lane
STE 262
Victoria, Texas 77904