NEW BEGINNINGS CHRISTIAN COUNSELING CLINIC— CLIENT REGISTRATION FORMS

CLIENT INFORMATION

1. Client Name: _____ (Last) (First) (Initial)

2. Address: _____ (Street) (City) (State) (Zip)

3. Home #: (___) _____, 4. Work #: (___) _____, Ext._____, 5. Cell #: (___) _____

6. Birthdate: _____ 7. Sex : M F 8. Marital Status: S M D W

9. Employer: _____ Tele: (___) _____ Occupation: _____

10. Student/School: _____ ❑ Full Time ❑ Part Time

11. Emergency Contact: Name: _____ Relationship: _____ Tele: (___) _____

12. Referred By: _____

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

1. Name: _____ Birthdate: _____ (Last) (First) (Initial)

2. Address: _____ (Street) (City) (State) (Zip)

3. Home #: (___) _____ 4. Cell #: (___)_____ 5. Work #: (___) _____

6. Relationship To Client: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

ALL FEES ARE DUE AT THE TIME OF THE APPOINTMENT. Fees are due for any scheduled appointment unless the appointment is cancelled twenty-four (24) hours in advance. If your insurance will cover our services, it is necessary that you first **pay our fees yourself** and then collect from your insurance company.

I authorize the release of any medical information requested by my insurance company that is necessary in the processing of claims. _____ (Initial Here)

SIGNED _____ **DATE:** _____

CLIENT/RESPONSIBLE PARTY

NEW BEGINNINGS CHRISTIAN COUNSELING CLINIC

FEE POLICY
APPOINTMENT CONFIRMATION CONSENT

Name: _____

The rates and billing for my visit(s) have been clearly explained to me and I understand my responsibility in the payment process. I realize that I am ultimately responsible for payment to New Beginnings for services rendered for my treatment and diagnosis.

I understand that, should I choose to bill my insurance company for services rendered at New Beginnings, I am nonetheless responsible for making full payment at the time the service is rendered. **New Beginnings advises all clients to make and retain copies of all superbills before sending originals to insurance companies**. It is very time consuming for our office to make copies or reprint your back superbills, and it is possible that you will be charged a fee for that service should you or your insurance company misplace them.

I also understand that New Beginnings has a 24-hour cancellation policy. If I cancel an appointment(s) less than 24 hours before the time of that appointment(s), or if I fail to keep a scheduled appointment for whatever reason, I understand that an attempt will be made by New Beginnings to fill that appointment time. If , however, the Clinic is unable to fill that time slot, I WILL BE REQUIRED TO PAY IN FULL FOR THE MISSED APPOINTMENT(S) PRIOR TO BEING SEEN AT THE CLINIC AGAIN. I realize that there will be no exceptions to this policy. In the case of 3rd party payment arrangements, I realize that missed appointment(s) are not billed to that 3rd party but rather that I am fully responsible for the payments of the missed appointment(s). (Please remember that you are responsible for keeping your appointment. Reminder calls are a courtesy that we try to provide our clients).

I further authorize New Beginnings to call me at the telephone number(s) given on my registration form unless otherwise noted.

If a client is involved in family, marital or group counseling, all adult parties must read and sign this form. Thank you

_____ _____

Signature(s) of Client(s)

_____ _____

Signature of Parent or Guardian Date

NEW BEGINNINGS CHRISTIAN COUNSELING CLINIC

Thank you for allowing us to serve you. Please take a few moments now to complete the information below. It will help us in understanding your situation more completely. If you have any questions, your counselor will be more than happy to discuss them with you. We believe that you have the right to be treated with dignity and respect, so be assured that all information will be treated confidentially.

Name: _____ Date: _____

Briefly describe why you are here.

_____

_____

_____

Why did you decide on New Beginnings Christian Counseling Clinic?

_____

_____

Have you had counseling or seen a Psychiatrist before? ❑ Yes ❑ No If so, please explain why you were seen, when you were seen, and who you saw.

_____

_____

Please list all individuals currently living with you.

Name	Relationship	Sex	Age	Occupation/Grade

Please describe what you would like to accomplish during your treatment.

_____

_____

_____

_____

NEW BEGINNINGS
CHRISTIAN COUNSELING CLINIC

Place a check by any of the following symptoms you are now or have ever experienced. Place a plus mark (+) by symptoms that are most prominent at the current time:

- ❑ Depression
- ❑ Crying spells
- ❑ Moodiness, changeable moods
- ❑ Difficulty staying asleep
- ❑ Difficulty getting to sleep
- ❑ Loss of appetite
- ❑ Lack of energy
- ❑ Loss of interest
- ❑ Loss or decrease of sex drive
- ❑ Restlessness
- ❑ Anxiety or nervousness
- ❑ Panic attacks
- ❑ Thoughts of suicide
- ❑ Fears or phobias
- ❑ Fear of being alone
- ❑ Fear of "going insane"
- ❑ Recurrent thoughts or worries
- ❑ Feeling compelled to do things
- ❑ Poor memory
- ❑ Periods of "going blank"
- ❑ Confusion
- ❑ Indecision
- ❑ Racing thoughts
- ❑ Family history of emotional problems
- ❑ Problems with trust
- ❑ Problems with trusting God
- ❑ Problems forgiving God
- ❑ Problems with religion
- ❑ Spiritual conflicts
- ❑ Alcohol abuse
- ❑ Sexual abuse
- ❑ Sexual dysfunction
- ❑ Educational problems
- ❑ Feelings of inferiority
- ❑ Problems with thought life
- ❑ Problems with children
- ❑ Problems with in-laws
- ❑ Problems setting or keeping goals
- ❑ Feelings of doom or death
- ❑ Shyness
- ❑ Loneliness
- ❑ Problems with self-esteem
- ❑ Sensitivity to criticism
- ❑ Sensitivity to rejection
- ❑ Over-dependency on others
- ❑ Jealousy
- ❑ Temper Outbursts
- ❑ Violent behavior
- ❑ Trouble getting along with others
- ❑ Suspiciousness
- ❑ Hallucinations
- ❑ Guilty conscience
- ❑ Feelings of unreality
- ❑ Unusual habits
- ❑ Work problems
- ❑ Headaches
- ❑ Stomach problems
- ❑ Bowel upsets
- ❑ Palpitations (heart irregularities)
- ❑ Chest pain
- ❑ Back pain
- ❑ Tingling or numbness
- ❑ Seizures or convulsions
- ❑ Loss of consciousness
- ❑ Dizziness
- ❑ Weight problems
- ❑ Eating problems
- ❑ Increased number of stressors in life
- ❑ Marital problems
- ❑ Problems forgiving others
- ❑ Problems forgiving myself
- ❑ Drug abuse
- ❑ Problems controlling impulses
- ❑ Problems with certain memories
- ❑ Financial difficulties
- ❑ Legal problems

Name: _____ Date: _____

NEW BEGINNINGS CHRISTIAN COUNSELING CLINIC
CONSENT TO USE AND DISCLOSE HEALTH CARE INFORMATION

This form is an agreement between you the Client, and New Beginnings Christian Counseling Clinic. If you are the client's adult guardian or legal representative, please sign the clients name below:

_____

Your medical records are confidential and will be written and stored at New Beginnings Christian Counseling Clinic. However, there are times when your medical record may need to be shared with other therapists or psychiatrists within this clinic. These professionals are legally bound to keep your records confidential as well. It may be necessary also to share your information with others who provide treatment to you, outside of this office, or perhaps to another party who needs it to arrange payment for your treatment or for other business or government functions. By signing this form, you are agreeing to let us use your information, referred to as Protected Health Information (PHI), and send it to others, such as insurance companies, payment sources or to other Therapists or Doctors we might need to refer you to.

There are also instances in which we may be required to release medical records, such as if a judge subpoenas your records or our testimony by Court Order; if it is believed that you are threatening serious bodily harm to yourself or to someone else, protective action such as contacting 911 emergency, the police or family members may be necessary; if it is believed that you are involved in abuse to a child or an elderly or disabled person, by law, we must file a report with the appropriate state agency.

If, due to changing laws, we are required to change our Notice of Privacy Practices, you may get a copy by calling us at 210.854.9819 This office reserves the right to change our Privacy Practices in accordance with applicable law.

If you are concerned about some of your information, you have the right to ask us not to use or share some of that information for treatment, payment or administrative purposes. You will have to tell us exactly what you want in writing.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on. However, we may have already used or shared some of your information upon receipt of your letter and will not be able to change that. New Beginnings Christian Counseling Clinic, its employees and all independent contractors in its association cannot be held responsible for the mishandling of your medical records once they are released from this office.

I have read and understand the above information and all of my questions have been answered to my full satisfaction.

_____ _____
Signature of Client or His/Her Personal Representative Date

_____ _____
Printed Name of Client or Personal Representative Relationship to Client