PSYCHOLOGICAL & COUNSELING SERVICES, PC

PERSONAL DATA SHEET

TODAY'S DATE:_____________________

CLIENT NAME:___________________________ **DATE OF BIRTH**:__________________

SOCIAL SECURITY NUMBER:________________

HOME ADDRESS (INCLUDE ZIP):____

PREFERRED CONTACT NUMBER:___________________ LEAVE MESSAGES AT THIS NUMBER? □ Y □ N

ALTERNATE CONTACT NUMBER:___________________ LEAVE MESSAGES AT THIS NUMBER? □ Y □ N

PRIMARY INSURED'S PLACE OF EMPLOYMENT:____

TYPE OF INSURANCE:___________________________ **MEMBER NUMBER**:______________________

INSURANCE COMPANY CONTACT PHONE:____

PRIMARY INSURED'S NAME, SSN, DOB (IF NOT CLIENT):_______________________________________

PERSON COMPLETING FORMS (IF NOT CLIENT):____

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE: I hereby authorize Psychological & Counseling Services to release to my insurance company all information necessary to obtain authorizations or support any insurance claims on this account and secure timely payments due to the assignee or myself.

SIGNATURE (Patient or Parent/ Guardian)_________________________ Date______________

STATEMENT OF FINANCIAL RESPONSIBILITY: I agree to be financially responsible for the charges that occur today and any subsequent charges that may occur. I understand that I am responsible for any claims not paid by my insurance coverage.

I also understand that I am responsible for half the session fee if I fail to cancel within 24 hours or fail to appear for an appointment.

SIGNATURE of Person Responsible for Account_________________________ Date______________

HIPAA PRIVACY NOTICE: I acknowledge receipt of the HIPAA Privacy Notice.

SIGNATURE (Client):____ Date______________

SIGNATURE (Parent/ Guardian):_____________________________________ Date______________

PSYCHOLOGICAL & COUNSELING SERVICES, PC

INFORMED CONSENT FOR TREATMENT

TODAY'S DATE:_____________________

CLIENT NAME:________________________ **DATE OF BIRTH**:__________________

SOCIAL SECURITY NUMBER:_____________

(Note: If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.)

I give consent for evaluation and treatment to be provided for myself/my child by (name of therapist) ____________________________________.

- I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
- The risks, benefits, side effects and alternatives of treatment as well as the consequences of noncompliance with treatment have been discussed with me and I have had the opportunity to ask questions.
- I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.
- I understand that I may terminate treatment at any time.
- I understand that what is discussed in therapy is confidential unless and until I (the client or parent) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate other person(s) if:
    1. The therapist believes that I am in danger of hurting myself or someone else, and
    2. If there is reasonable suspicion that a child has been abused or neglected.

My signature below shows that I understand and agree with all of the above statements. I will have ongoing opportunity to ask questions about the treatment process.

____ ___________________
Signature of Client or Parent/Guardian Date

____ ___________________
Printed Name Relationship to Client

____ ___________________
Witness Signature Date

Psychological & Counseling Services, PC 12728 Augusta Ave., Ste. 150 Omaha, NE 68144
402.330.1537 (office), 402.330.9331 (fax)