Blue Star COUNSELING

Client Information Sheet—Adult Client

Client's Name: _____Client's Date of Birth: _____

Client's Address: _____

City: _____ Zip: _____ Sex: Male Female Trans

Contact information:

Cell Phone: _____ Voicemail msg? _____ Text msg? _____

Alternate Phone: _____ Voicemail msg? _____ Text msg? _____

Email address: _____ Email o.k.? _____

Emergency Contact's name: _____ Phone: _____ Msg? _____

How did you hear about my therapy services? _____

Insurance Information: (Primary Insurance)

Name of Mental Health Insurance: _____Insurance Phone #: _____

Mental Health Claims Address: _____

Insured/Sponsor's Name: _____Insured's Date of Birth: _____

Insured/Sponsor's Address: _____

Insured/Sponsor's ID # (off of insurance card): _____

Group #: _____ ***Client's*** Relationship to Insured: Self Spouse Child

Insured's Employer Name: _____

Do you have other insurance? Yes No

Name of Mental Health Insurance: _____Insurance Phone #: _____

Mental Health Claims Address: _____

Insured/Sponsor's Name: _____Insured's Date of Birth: _____

Insured/Sponsor's Address: _____

Insured/Sponsor's ID # (off insurance card): _____ ***Client's*** Relationship to Insured: Self Spouse Child

Group #: _____ Insured's Employer Name: _____

SIGNATURE ON FILE

I attest that all of the information above is correct to the best of my knowledge. I authorize release of any medical or other information necessary to process claims to my insurance companies. I authorize payment of medical benefits to the physician or supplier for services described on insurance claims. I understand that verification of insurance benefits it not a guarantee of payment and that any unpaid balance is my responsibility.

_____ _____

Signature Date

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Adult Psychosocial History Information

Name: _____ Birthdate: ____/ _____/_____ Age: _____

Family Relationships:

Current Romantic Relationship Status: _____ If married, how long? _____

If separated, how long? _____ If living together, how long? _____

Current Spouse/Partner's Name: _____ Age: _____

Former Spouse/Partner's Name: _____ If divorced, how long ago? _____

Children:

Name: _____ age: _____ Name: _____ age: _____

Name: _____ age: _____ Name: _____ age: _____

Name: _____ age: _____ Name: _____ age: _____

Name: _____ age: _____ Name: _____ age: _____

List any specific concerns about your children: _____

_____

_____

List other family members with whom you have frequent contact (i.e. mother, father, siblings, etc.) _____

_____

Work History:

Are you currently employed? Y / N If yes, place of employment: _____

Position/Job Duties: _____

Is your work stressful? _____

Physical History:

Past Medical Concerns:_____

Current Conditions: _____

Allergies: _____

List Current Medications and reasons (including psychotropic medications): _____

_____

_____

Do you have healthy eating and sleeping habits? _____

Please complete page 2

Habits (show frequency)
Tobacco: _____ Alcohol: _____ Illegal Drugs: _____ Exercise: _____
Other: _____

Mental Health History
Please identify if you or anyone in your family has a history of the following:

	Please circle	If family member. specify relationship:
Alcohol/Substance Abuse	self	family
Anxiety	self	family
Depression	self	family
Domestic Violence	self	family
Eating Disorder	self	family
Obesity	self	family
Obsessive Compulsive Disorder	self	family
Schizophrenia	self	family
Suicide attempts	self	family

Have you been in counseling before? _____ When? _____
How long? _____
Why terminated? _____

Hobbies you enjoy: _____

In what area(s) do you want help? _____
_____
_____
_____

How has the above problem(s) impacted your daily life? (circle number in each area)

	Minimally>>>>>>>>>>					Half the time>>>>>>>>>>>>>>				Totally
Physically	1	2	3	4	5	6	7	8	9	10
Mentally	1	2	3	4	5	6	7	8	9	10
Socially	1	2	3	4	5	6	7	8	9	10
Academically	1	2	3	4	5	6	7	8	9	10
Spiritually	1	2	3	4	5	6	7	8	9	10

Was there a time in the last year that you felt you were coping well with this problem? ____Yes ____No

Anything else you feel that the counselor needs to know as you begin? _____
_____
_____
_____

Blue Star COUNSELING

Kathryn Zentner, LCSW *8701 Shoal Creek Blvd, Ste 403, Austin, TX, 78757*

OFFICE POLICIES

Sessions are 50 minutes long. You are expected to arrive at your appointment time.

My fee is $150 for the initial interview and/or assessment appointments, $125 for family therapy, and $125 for individual therapy. Longer sessions will be prorated based on the basic fees. Payment or co-payment is due at each session. Costs for court testimony are $600 per half day (or portion of a half day), payable in advance. Separate office policies are required for individuals involved in court proceedings.

Regular attendance at scheduled appointments is one of the keys to a successful outcome in counseling. When you make an appointment, I reserve your appointment time for you. You are expected to notify me at least 48 hours in advance if you cannot attend a scheduled appointment. **Any cancellations within 24 hours of your appointment time will assess a $75 cancellation fee *regardless of the reason for the cancellation***. If you fail to keep an appointment without notice, I will charge you the entire session fee of $125. These fees cannot be billed to insurance. You may cancel an appointment by calling or texting (512) 497-2177.

I am aware of this cancellation policy: _____ (initials)

I will bill your insurance when applicable and as requested by you. It is your responsibility to make sure I am a participating (in network) provider on your plan and to know the limitations of your coverage. Your insurance company may limit the number of sessions based on their assessment of medical necessity or other factors. **Benefits quoted by your insurance company are not a guarantee of payment.** You are responsible for any co-pays, deductible amounts, and any other fees that are not covered by insurance. Payment is due at the time of service unless you have made special arrangements with me. In some cases I may ask you to supply a credit card as a secondary form of payment in case your claim is denied or you have not met your deductible.

Insurance companies routinely ask for patient information, including diagnosis and treatment plans to authorize payment. When you request that I bill your insurance company for my services, you are agreeing that I can release this information to them.

If you have an emergency or have an urgent need to speak with me, you may leave a message in my confidential voice mail box by calling (512) 497-2177. I attempt to return all calls within 24 hours. If I am not able to return your call within a reasonable amount of time, or I am unavailable for a longer period of time (i.e. on vacation), you are responsible for seeking help from community resources or the local emergency room or psychiatric hospital.

Texting and email are permitted, but as they are not guaranteed forms of confidential communication, I ask that they be used sparingly. If you let me know that you would like for me to contact you via texting or email, you should be aware that electronic communication is preserved, may be compromised, or may be viewed by people who have access to your personal device. At the same time, I recognize that checking in, contacting me regarding scheduling matters, etc, might be most effectively accomplished by texting or email. If you would like for me to communicate with you on a limited, as needed basis, with the understanding that there are limits to the privacy and confidentiality of this form of communication, please initial here: _____

Throughout our time together we will discuss your treatment goals for therapy. Therapy is a joint effort between the therapist and client, the results of which cannot be guaranteed. Progress depends on many factors, including motivation, effort, and other life circumstances, such as interactions with family, friends, and other associates. Unfortunately, there are no instant cures and therapist and client must work together to move the client in the direction the client wants to go. You are encouraged to discuss any concerns and/or questions about treatment with me at any time.

I agree that I will be responsible for the payment of all professional fees. I have read and understand the policies listed above. I have received a copy of these policies for my records.

Signature of client _____ Date_____

Printed name of client _____