General Information Clinician Name:
Patient Name:
DOB:
Age:
Address:
City and Zip Code:
Email Address:
Phone number where we may leave a message:
Secondary phone number:
Sex:
Marital Status:
Who may we contact in case of a medical or mental health emergency?
Name:
Phone:
If the patient is a minor:
Parent Name:
Phone:
Address:
Who is financially responsible for services and/or the insured party: Patient Parent
Psychiatrist Name and Phone:
Primary Care Physician Name and Phone:

Insurance Information

Name of Insurance Company:
Name of Insured:
Insured Person's Relationship to Patient:
Insured Person's Date of Birth:
Policy Number:
Mental Health Claims Phone:

Credit Card Information (Required of ALL clients regardless of billing or payment arrangements)

Cardholder's Name:
Card Type: Visa Discover American Express Master Card
Account Number:
Expiration Date:
Verification Number (three numbers on back of the card):
Zip Code for Card's billing address:

I authorize InnerEssence Counseling and Clinical Hypnotherapy, to keep my credit card on file and charge my credit card for the **cancelation fee ($50.00**) **for any appointment missed or canceled with less than 24 hour notice as well as for any outstanding balance upon termination.** I understand that this authorization is valid for one year unless I cancel the authorization through written notice to Houston Psychotherapists, Inc.

Printed Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

Notice of Privacy Practices and Acknowledgements

I understand that, under the Health Insurance Portability& Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Authorization for the Release of Information

Client Name:_____**Date of Birth:** _____

*I,*_____*authorize*_____*. to disclose and receive information relevant to my care and treatment with the individual named below:*

Person to whom information may be released: _____

Address:_____

Phone:_____**Fax:** _____

Information Authorized to be Released (Please check all that apply):

___Information pertaining to Scheduling, Billing, and Administrative Concerns

___Diagnosis, Treatment Plan, and Progress

___Bio-psychosocial History and Background

___Information pertaining to Substance Use

___Information pertaining to HIV/AIDS

___Copy of Testing and Assessment Records

___Copy of Complete Medical Record

___All of the Above AND Any and All Information Requested

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has already been taken. This consent shall expire 90 days after the date of client discharge unless another date is specified.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

Signature of Client/Parent/Legal Guardian: _____

Date on which information may be released: _____

Date on which authorization is revoked (OPTIONAL): _____

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