Patient Information Sheet

Patient Name: ______________________________ Date of Birth: __________Gender: ______

Home Address:____

City:_____________________ State:____________ Zip Code:_________________

Home Phone: (   ) _______________ Work Phone: (   )____________________

Cell Phone: (   ) ________________ Email:______________________________

Employment (patient):

Employed   Full-Time Student   Part-Time Student   Unemployed/Other

Would you like an appointment reminder? (circle one):

Email Only   Text Only   Text and Email   Text or Call and Email

Do we have your permission to leave a voicemail? (circle one):   Message   No Message

Referred By

Facility Name: ______________________ Name of Doctor/Contact:____________________

Address:____

City:_____________________ State:____________ Zip Code:________________

Phone: (   )___________________ Email:________________________________

PSYCHOLOGY HOUSTON, PC

THE CENTER FOR COGNITIVE BEHAVIORAL TREATMENT

If patient is a minor, please complete the following:

Parent/Legal Guardian's Name: ________________________________

Phone Number: Home: ( ) ______________ Work: ( ) ______________

Cell: ( ) ______________ Email: ______________________________

Would you like an appointment reminder? (circle one):

Email Only Text Only Text and Email Text or Call and Email

Do we have your permission to leave a voicemail? (circle one): Message No Message

Parent/Legal Guardian's Name: ________________________________

Phone Number: Home: ( ) ______________ Work: ( ) ______________

Cell: ( ) ______________ Email: ______________________________

Would you like an appointment reminder? (circle one):

Email Only Text Only Text and Email Text or Call and Email

Do we have your permission to leave a voicemail? (circle one): Message No Message

Emergency Contact (if patient is not a minor)

Name: ______________________ Relationship to Patient: ______________

Address: ____

City: ______________ State: __________ Zip Code: ______________

Phone: ( ) ______________ Email: ______________________

Consent

Your signature below indicates that you have read the information in the Policies, Procedures, and Informed Consent document and agree to abide by its terms during our professional relationship.

______________________________ _______________

Patient/Legal Guardian Signature Date

HIPAA

Your signature below indicates that you have read the information in the HIPAA document and agree to abide by its terms during our professional relationship.

______________________________ _______________

Patient/Legal Guardian Signature Date

I agree to allow Psychology Houston, PC to send a letter of acknowledgement to my referring clinician thanking them for the referral. This letter will not contain any clinical information, only acknowledging that I/my child was seen at this clinic.

______________________________ _______________

Legal Guardian Signature Date

For Parents/Legal Guardians

I, (Print)______________________________, the parent/legal guardian of the minor,

______________________________, give my permission for this minor to receive psychological treatment.

I am the legal custodian of this child, and there are no court orders in effect that would prohibit me from consenting to the treatment of this child.

______________________________ _______________

Legal Guardian Signature Date

PATIENT INFORMATION REGARDING PROFESSIONAL FEES

The purpose of this agreement is to clarify your financial responsibilities and allow us to focus on what is most important to all of us - helping you.

I understand that payment is expected at the time of service. Payment can be made by cash, check, health savings account, or credit card. Checks should be made to **Psychology Houston, PC.**

I authorize Psychology Houston, PC to charge my credit card.

Credit card #_______________________________ CVV # ________________

Exp. Date________Zip______________. (Note** Zip code must be for the billing address)

Please initial by each statement:

_____ **1. I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. NO EXCEPTIONS WILL BE MADE.** Cancellations should be via phone 713-914-9944 or email at info@psychologyhoustonpc.com.

_____ **2. I UNDERSTAND THAT I WILL BE CHARGED FOR PHONE CALLS OR OTHER SERVICES LASTING LONGER THAN 10 MINUTES.** Charges will be determined based on the length of time the service was provided. Patients frequently request forms and letters for school, work, or insurance issues. If time permits, brief forms may be completed during your allotted appointment time and there will be no additional charge. Longer forms and letters will be done outside of appointment time and the fee will be based on the time involved to complete this service.

_____ **3. I UNDERSTAND THAT I WILL BE CHARGED FOR ANY PSYCHOLOGICAL ASSESSMENTS REQUIRING MORE THAN 10 MINUTES OF TIME FOR SCORING AND INTERPRETING RESULTS.** Charges will be determined based on the length of time required for scoring and interpreting results.

_____ **4. I UNDERSTAND THAT I WILL BE CHARGED AT A RATE of $500.00 PER HOUR (minimum of 3 hours) FOR COURT APPEARANCES OR LEGAL PROCEEDINGS.**

I agree to advise the receptionist of any change in my address, phone number, or other personal information that has occurred since my last appointment.

WE WANT TO BE CLEAR THAT THE FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED IS YOURS AND THAT INSURANCE IS FOR YOUR REIMBURSEMENT. We do not bill insurance companies directly. Your statement contains the information you will need to file with your insurance company.

It is our policy to designate one parent as financially responsible for services provided to children. If Court Orders (e.g. custody agreements) specify other financial agreements (e.g. each parent responsible for 50%), it becomes the responsibility of the designated parent to obtain reimbursement from their ex-spouse.

Patient's Name____ Date_____________

Patient's Signature (If 18+)________________________________ Date_____________

Parent/Guardian Name (If patient is a minor)__________________ Date_____________

Parent/Guardian Signature (If patient is a minor)________________ Date_____________