Cleary Counseling and Consultation, Inc
Jacquyn R Cleary, MS, LPC, LMFT
1811 S. Baltimore Suite 200
Tulsa, OK 74119
918.978-0176

Date_____

CHILD/ADOLESCENT INFORMATION

Client Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Child Cell _____ Child Email _____

School _____ Grade _____ Religious Affiliation _____

PARENT/GUARDIAN INFORMATION (If applicable)

Father's Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work # _____ Cell # _____

Birth date _____ Social Security # _____

Occupation _____ Place of Employment _____

Education (Highest Grade Completed) _____ Marital Status _____

Religious Affiliation _____

Mother's Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work # _____ Cell # _____

Birth date _____ Social Security # _____

Occupation _____ Place of Employment _____

Education (Highest Grade Completed) _____ Marital Status _____

Religious Affiliation _____

SIBLINGS

Name	Birth date/Ages	Grade in School	Living at Home

Whom should we contact in case of an emergency? _____

Telephone Number _____ Relationship _____

Preferred way of confirming appointments: _____Home _____Cell _____ Text _____E-mail

Whom may we thank for referring you to us? _____

May we send a thank-you to the referral source? Yes _____ No _____

1. Briefly describe the problem for which you are seeking help.

2. How do you think we can best assist you?

3. Who is your personal physician/pediatrician? _____

4. When was your last physical examination? _____

5. Please describe any physical disabilities or health problems.

6. Please list any medications you are now taking.

7. Please describe any additional information that might be helpful in our understanding of the problem.

8. Describe the type and frequency of your exercise.

9. Have you or your child received psychiatric help or psychological counseling before? (Circle)YES NO

If yes, with whom and dates? _____

Please check any of the following symptoms/problems that pertain:

- ☐ Fears or phobias
- ☐ Shyness
- ☐ Having to do things over and over
- ☐ Intrusive thoughts
- ☐ Making decisions
- ☐ Need to be in control of everything
- ☐ Nightmares
- ☐ Relaxation
- ☐ Stress
- ☐ Coping with a traumatic event
- ☐ Unresolved grief
- ☐ Depression
- ☐ Unhappiness
- ☐ Inferiority Feelings
- ☐ Suicidal thoughts
- ☐ Lack of ambition
- ☐ Blocked emotions
- ☐ Tiredness
- ☐ "Up-and-down" feelings
- ☐ Lack of Energy
- ☐ Loss/Increased Appetite
- ☐ Sleep problems
- ☐ Concentration
- ☐ Procrastination
- ☐ Memory
- ☐ Relationship problems
- ☐ Loneliness
- ☐ Anger/Temper
- ☐ Frustration
- ☐ Self control
- ☐ Headaches
- ☐ Stomach Problems
- ☐ Bowel Problems
- ☐ Health Problems
- ☐ Weight
- ☐ Sexual Problems
- ☐ Alcohol or drug use
- ☐ Education
- ☐ Work
- ☐ Career choices
- ☐ Parents' Separation/Divorce
- ☐ Legal Matters

Parenting Issues

- ☐ Discipline
- ☐ Divorce Issues
- ☐ Parenting Skills

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CONSENT FOR TREATMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I acknowledge that I have received, read, and understand the policies and procedures as described in the Client Information forms and do so indicate by affixing my initials next to each of the following points:

_____ 1) Confidentiality - I am aware that an authorized agent of my insurance carrier or other third party payer may request and be provided with information about the type(s), cost(s), and date(s) of any services or treatments I receive so that payment may be provided to my therapist.

_____ 2) Payment and Billing Policies - I am aware that I am responsible for payment in full for any charges for services provided on my behalf unless they are specific services provided under the benefit plans of my insurance and as designated in any contract between my therapist and my insurance company and its lawful delegates.

_____ 3) Financial Responsibility - I am aware that I may terminate treatment at any time without consequence, but that I will still be responsible for payment of the services I have received. I am aware that if I have not paid for services received, my treatment may be discontinued and my account turned over for collection.

_____ 4) Appointments and Cancellations - I am aware that any cancellations of appointments must be made at least 24 hours in advance of the appointment and if I do not cancel or do not show up I will be charged for that appointment.

_____ 5) Intra-agency Consultation - I am aware that my therapist may consult or share information with other members of the professional staff in the therapeutic office if such consultation can be expected to be helpful in dealing with a problem being discussed in therapy and that those staff may have access to relevant information in my client file. I am also aware that no information about me or my situation may be communicated to others outside this therapeutic office without my explicit permission unless such action is required by law.

_____ 6) Risks of Psychotherapy - I am aware that the practice of psychotherapy is not an exact science and that predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the therapist identified below.

_____ 7) Court Testimony and Custody Evaluations – I am aware that therapists make every effort to maintain client confidentiality and therefore do not testify in court regarding custody, divorce action, or other legal matters. I agree not to contact my therapist personally or via my attorney to testify in court. If my therapist is contacted/subpoenaed on my behalf for testimony, I agree to pay all court costs, legal fees, and hourly rates for my therapists time.

_____ 8) I do _____ do not _____ have questions about this consent for treatment/financial policy.

I do hereby seek and consent to participate in evaluation and or treatment with the therapist identified below.

_____ _____
Parent or Guardian of Minor Child Date

_____ _____
Therapist Date

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Business Policies

Our experience has been that counseling and psychotherapy are most effective when expectations regarding fees, billing, insurance, reimbursement, and cancellation policies are understood by all parties in advance. Please review the information below, and feel free to ask if there are any questions.

FEES
For individual, marital, and family therapy(most sessions are 50 minutes in length. Longer or shorter sessions may be recommended in certain circumstances):

Initial 50-minute session……$175.00
50-minute session ……..$140.00

Other fees may be charged for specific services, such as hospital visits, consultation with attorneys or other professionals, structured group programs focusing on a particular topic or problem, detailed psychological evaluations completed at the request of a physician or attorney, etc. We would be happy to discuss our fees for these services with you at any time.

In some situations, clients may be asked to complete psychological testing instruments. Fees for other test will be communicated in advance and vary according to the nature of the test.

INSURANCE
Health plans vary widely in their mental health benefits, and most plans have both yearly and lifetime benefit limits. Further, many "managed care" plans periodically review your symptoms or progress in therapy and may markedly restrict the number of sessions authorized for insurance payment. **It is your responsibility to familiarize yourself with the authorization procedures, reimbursement rate, limitations, and specific provisions of your health policy, although we will be happy to help when we can if there are questions. Keep in mind that even if you have insurance , you are the one who is ultimately responsible for payment of your bill.** This is true even if the insurance company withdraws authorization for services after the services has been received. We cannot take responsibility for negotiating settlements on any disputes with your insurance company.

PAYMENT
We can usually estimate fairly accurately the amount of our fee that will be covered by your insurance. Payment for the non-insured portion of your bill (the "co-pay") is due at the time services are rendered. If this is not possible, discuss the situation with us to see if alternative arrangements can be made. Services may be discontinued if fees remain unpaid for an extended period of time. We reserve the right to retain a collection agency or attorney to collect unpaid fees after termination of therapy if the former client fails to make a reasonable effort to pay off any outstanding balance.

CANCELLATIONS AND MISSED APPOINTMENTS
If you cannot keep an appointment, please notify our office at least 24 hours in advance so that we can reschedule someone else for the time that has been reserved for you. We have a courtesy reminder for appointments and would appreciate a timely response to those reminder calls so that we can fill the space promptly with clients who are available and need the service. We have an administrative fee that may be applied to cover costs and administrative time if cancellations are less than 24 hours in advance of scheduled appointments. The fee is currently $140.00. Unless we are able to reschedule with shorter notice, **the regular fee may be charged for appointments missed without notice or canceled with less than 24 hours' notice.** There is no charge for appointments canceled due to illness or emergency if the office is notified prior to the scheduled appointment time.
My signature below indicates that I have read, that I understand, and that I agree to the business policies outlined above. I agree to assume financial responsibility for the cost of services to me or to the person whose name appears below. I authorize Cleary Counseling to act as my agent in helping me obtain payment from my insurance company (if applicable). I agree to the release of whatever information is necessary for the insurance company to process my claim. Unless I pay in full at the time of each session, I authorize my insurance company to pay benefits directly to Cleary Counseling. I permit a photocopy of this authorization to be used in placed of the original.

Printed Name of Client: _____ Client Date of Birth:_____

Responsible Party if Client is a minor:_____SSN:_____

Signature of Adult Client or Responsible Party:_____