Kenneth "Chuck" Houston, LCSW

For Office Use Only

Dx: _____ PP Rate _____

Client Face Sheet

Confidential

Intake Date:

Patient Name: *First* *Middle Initial* *Last*

Responsible Party (Circle : Self Parent Spouse) *First* *Last*

Address: Apt. #

City: State: Zip:

Home Phone: ( ) Work Phone: ( ) Ext.

Cell Phone: ( ) Is it okay to call your work number? Yes No

Gender: ☐ Male ☐ Female Patient Date of Birth: Age:

Marital Status: ☐ Married/Partner ☐ Single ☐ Divorced
☐ Separated ☐ Widowed ☐ N/A (Child)

Employment Status: ☐ Employed ☐ Student Full-Time
☐ Employed/Student ☐ Unemployed ☐ Other _____

Primary Insurance & Address: _____

_____

_____

Insurance Co. Phone Number: _____

Name of Insured (Subscriber): _____ Subscriber Date of Birth: _____

Subscriber's Employer: _____

Subscriber ID # (Plan #): _____ Group #: _____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (Explain: _____)

Secondary Insurance & Address: _____

_____

_____

Insurance Co. Phone Number: _____

Name of Insured (Subscriber): _____ Subscriber Date of Birth: _____

Subscriber's Employer: _____

Subscriber ID # (Plan #): _____ Group #: _____

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (Explain: _____)

I hereby authorize my insurance benefits to be paid directly to provider of service. I also authorize the release of any information required to process this claim.

Signature _____ Date _____

Kenneth Chuck Houston continues to participate in training in specialized areas to be able to provide quality treatment to clients.

In the sessions, Kenneth Chuck Houston will establish the nature of the problem and what will be involved in treatment. Length of treatment will vary depending on the nature of the issue(s), commitment to the therapeutic process and how this fits with your treatment goals. Please feel free to ask questions since ultimately the responsibility for choosing the best provider for treatment is your decision.

Master in Social Work, Portland State University, 1984
Oregon Licensed Clinical Social Worker, #0985
Washington Licensed Clinical Social Worker #250

Additional Information

Clients Employer: _____ Occupation:_____

(If client is attending school) School:_____ Grade:_____

Spouse/Parent name:_____ Social Security#:_____

Age: _____ Date of Birth:_____ Contact Phone: _____

Employer_____ Occupation _____

Family Members

Name Age Relationship

_____

_____

_____

_____

_____

Kenneth "Chuck" Houston, LCSW

Consent to Use or Disclose Clinical Information

I authorize **Kenneth "Chuck" Houston, LCSW** to use and disclose the health and clinical information of _____ *(Client)* for the purposes of **Treatment** (*including activities performed by this office providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this office as an on-call professional*), **Payment** (*including uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre certification and preauthorization*) and **Health Care Operations** (*including the administrative and business functions of this office*).

You should review my ***Notice of Privacy Practices*** for additional information about the uses and disclosures of information described in this ***Consent*** prior to signing this ***Consent***.

Because I reserve the right to change my privacy practices in accordance with the HIPAA Privacy Rules, the terms contained in the ***Notice of Privacy Practices*** may change also. A summary of the ***Notice of Privacy Practices*** will be posted in my office indicating the effective date of our current ***Notice of Privacy Practices*** in the upper right hand corner. We will offer you a copy of the ***Notice of Privacy Practices*** on your first visit after the effective date of the current ***Notice of Privacy Practices.*** You will be given a copy of the ***Notice of Privacy Practices*** at your request.

As more fully explained in the ***Notice of Privacy Practices,*** you may have the right to request restrictions on how I use and disclose your protected health information for treatment, payment, and health care operations. *I am not required to agree to your request.* If I agree, I am required to comply with your request unless the information is needed to provide emergency treatment to you. Other practitioners who provide coverage for this office are required to use and disclose your protected health information consistent with my ***Notice of Privacy Practices.***

Verify that you have received a copy of the ***Notice of Privacy Practices*** by initialing here: ____

Payment in full is expected at time of service unless arrangements have been made to bill your insurance company. If we're billing your insurance company you are expected to make your copayment at each session. This is a courtesy service we provide for you – your are ultimately responsible. In addition, sessions that are cancelled without 24 hour notice, or missed appointments, will be billed to you at my full rate.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that this office has already used or disclosed the information in reliance on this Consent.

_____ *Date* _____

Signature of Client

_____ *Date* _____

Signature of Legal Guardian or Representative

Please indicate the nature of your relationship to the client _____

Emergencies

To reach Kenneth Houston in an emergency call (360) 695-0115 then press 112 on your phone after leaving a message in her voice mailbox. Kenneth will be paged and return your call as soon as possible.

If you have an emergency that cannot wait for a return call from Kenneth, or if Kenneth is not immediately available, contact the following 24-hour resources:

Crisis Hot Line…… ……. …… …… (360) 696-9560
S.W. Washington Hospital … …. ….. (360) 696-5232
Police… …. …….. …. …. ……. 911

Payment Policies

Payment is due at the time of service, unless prior arrangements are made with my bookkeeper. If you have insurance that will cover a portion of my fee, you will be expected to pay your copay before or after your session.

Fees

$ 202 – Evaluation interview (First visit)
$ 111.54 – 45 to 60 minute individual, martial or family psychotherapy session
$ 250 per hour for court appearances
Failed appointments will be charged $50 per failed appointment

Failed Appointment Charges

Appointments canceled less than 24 hours in advance will be charged. Messages of cancellation may be left on my voicemail 24 hours a day, 7 days a week. Insurance does not cover charges for late, cancelled and failed appointments.

Professional Consultations

To provide services, it is sometimes necessary to request a consultation from another professional. (Examples: Physicians, Attorneys, Teachers and other mental health professionals). If a consultation were indicated, your name would not be released without your written consent.

Termination

You have the right to either terminate therapy or request referral to another therapist at anytime, provided you have not been mandated to therapy by an agency. Should you choose to do so, I request you discuss your decision in the therapy session. Since therapy is a cooperative and often emotional venture, I ask that you raise any such thoughts you might have so we can consider together the implications of such a change. Termination of therapy can also occur at my request. Possible termination reasons might include my no longer being able to assist you or that you are no longer able to assume financial obligations for treatment.

I have read and understand the policies of Kenneth Chuck Houston, and my participation in therapy, agree to these written policies and procedures.

_____ _____

Signature Date

Client Name: _____

1. PRESENTING PROBLEMS

Describe the problem that brought you here today:

CHECK ANY OF THE SYMPTOMS THAT YOU ARE HAVING:				(Clinician Space)
Depression		Feeling hopeless		
Extreme sadness		Feeling tearful		
Trouble concentrating		Change in sleeping habits		
Memory problems		Lack of energy		
Change in eating habits		Weight changes		
Feeling of extreme happiness		Change in sexual interest or function		
Trouble performing your job		Problems getting along with friends or family		
Lack of enjoyment of activities		Feeling Stressed		
Self-esteem problems		Easily irritated		
Perfectionism		Feeling guilty		
Obsession or compulsions		Feeling nervous		
Feeling fearful		Sudden feelings of panic		
Physical complaints of pain		Muscle tension		
Problems with anger		Acting violently		
Thoughts about hurting yourself or others		Thoughts about killing yourself or others		

2. Have you ever been seen in counseling before? Yes ☐ No ☐

If you have been in counseling before please describe it below.
Start with the most recent time first:

When did you have counseling?	Date(s):
Who did you see?	Name(s):
Explain what happened:	
When did you have counseling?	Date(s):
Who did you see?	Name(s):
Explain what happened:	

3. MEDICAL INFORMATION

Have you seen a doctor within the past year?	Yes ☐ No ☐
Why have you seen a doctor?	
Who is your doctor?	Phone #:
Are you taking any kind of medication? (Prescription or over-the-counter)	Yes ☐ No ☐
Please list the medicines you are taking:	
Do you have allergies to anything?	Yes ☐ No ☐
Please describe allergy problems that you have:	

4. SUBSTANCE USE HISTORY

Do you use/have used tobacco (any form)?	Current ☐ Past ☐ No ☐
Do you use/have used Alcohol?	Current ☐ Past ☐ No ☐
Do you use/have used Caffeine (Any form including cola drinks)?	Current ☐ Past ☐ No ☐
Do you use/have used recreational drugs?	Current ☐ Past ☐ No ☐
What kind(s) of drugs?	List :