New Patient Responsibility Procedure

Patient co-payments, co-insurances, and/or deductibles are due at the time of appointment.

_____

SIGNATURE DATE

1202 S Main St
STE 204
Little Rock, Arkansas 72202
(501) 406-0573

Glenn McCracken, LPC

Patient Information

Date: _____
Name: _____
Sex: M / F Age_____ DOB _____ SS#: _____
Home phone: _____ Cell phone: _____
Email: _____
Marital Status: Married / Single / Divorced / Widow / Minor
Physical Address: _____
City: _____ State/Zip: _____
Patient Employer: _____ Phone: _____
Spouses Name: _____ Phone: _____
Sex: M / F DOB: _____ SS#: _____
Spouse's Employer: _____
Responsible Party: _____ SS#: _____
Address: _____
Phone: _____
Emergency Contact: _____ Phone: _____
Address: _____
Relationship to patient: _____
Primary Care Doctor/Phone number: _____

If Patient is 18 years of age or younger:
Father's name: _____ Phone: _____ DOB: _____
SS#: _____ Father's employer: _____
Mother's name: _____ Phone: _____ DOB:_____
SS#: _____ Mother's employer: _____

Please briefly state your reason for seeking counseling: _____
_____
_____
_____

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_____

Are you currently taking any medications? Prescription or over the counter. ___Y ___N

If yes, specify type, dose, and reason for taking: _____
_____
_____

If prescribed, who prescribed them?: _____

Medical Concerns: _____
_____

Have you seen a therapist in the past? If so, when, and who?: _____
_____
_____

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Self Description Checklist (Please check all that apply)

__ alcohol abuse
__ anger
__ anxiety
__ apathetic
__ ashamed
__ changes in weight
__ cheerful
__ compulsions
__ concentration problems
__ confused
__ crying spells
__ dangerous
__ depression
__ difficulty with decisions
__ disappointed
__ distrustful
__ drug use/abuse
__ eating disorder
__ energetic
__ faith/religious problems
__ fatigued/low energy
__ feeling abandoned
__feeling inferior
__ feeling misunderstood
__ frequent pain
__ fretful
__ guilt feelings
__ happy
__ hearing strange voices
__history of abuse
__ hopeless
__ hurt
__ impulsive concerns
__inadequate
__isolated
__jealous
__legal difficulties
__lonliness
__loss of appetite
__marital conflict
__meaninglessness
__memory problems
__money problems
__mood swings
__mourning
__nausea
__obsessive thoughts
__optimistic
__panic
__parent conflict
__perfectionism
__physical illness
__poor motivation
__poor sex drive
__relationship difficulties
__resentful
__sexual problems
__shyness
__sleep problems
__social withdrawal
__specific fears
__stress
__suicidal
__suspicion
__thoughts of hurting others
__treated unfairly
__troublesome thoughts
__unhappy
__work conflict
__worry
__no concern
__indifferent
__irrational thoughts
__irritability
__unusual thoughts
__unusually sensitive
__violent

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Insurance Information

Primary Insurance: _____ Phone: _____
Address: _____
Name of Insured: _____ Phone: _____
SS#: _____ Group #: _____ ID: _____
Relationship to patient: Self / Spouse / Child / Parent / Other: _____

Secondary Insurance: _____ Phone: _____
Address: _____
Name of Insured: _____ Phone: _____
SS#: _____ Group #: _____ ID: _____
Relationship to patient: Self / Spouse / Child / Parent / Other: _____

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Counseling Agreement and Cancellation Policy

A minimum of 48 hours notice is required for cancelling or rescheduling your appointment. Please be considerate of other clients and reschedule/cancel as early as you are able to.

Cancellations after the 48 hour time period will result in a $50 fee. If cancelling occurs on the day of the appointment, the client will be responsible for the entire session fee allowable by insurance. This fee is due within 7 days of scheduled appointment. Failure to pay or establish a payment plan can result in other means to obtain payment (legal, collection agencies).

The only exceptions to this cancellation policy is if there is an emergency. Please note, work issues do not constitute an emergency. Some examples of an emergency are car accidents, deaths in the family or extreme illness. The cancellation policy applies even if missing the session was an unintentional act. In the event of extreme weather, sessions can be conducted by phone.
Couples Session: If at least one party is able to attend the session, there will be no cancellation fee. Phone sessions are paid up front in advance of the session.

Payment is due at the time of service. Time will be allotted before the end of the session to take care of financial matters and schedule future appointments.

A frequency of sessions is recommended in order to optimize the benefits from counseling. If client chooses to, or must, attend fewer sessions than recommended, please note that can compromise the effectiveness of treatment.

Client is able to use email for the purpose of rescheduling/cancelling sessions. Once a new session time is offered, both parties must confirm in order to claim the slot.

CONFIDENTIALITY
All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written consent, unless the disclosure is required by law. Some circumstances where disclosure is required by the law are: where reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled, or when a client's family members communicate that the client presents a danger to others.

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I have read and agree to the policies above.

Signature: _____ Printed Name: _____

Work #: _____ Cell #: _____ Home #: _____

Home Address: _____

Email: _____

Date: _____

If couples therapy, both parties must sign and agree to these policies.

Signature: _____ Printed Name: _____

Work #: _____ Cell #: _____ Home #: _____

Home Address: _____

Email: _____

Date: _____

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INFORMED CONSENT

I am voluntarily seeking counseling for my particular issue(s) and I am committed to working with my therapist to successfully resolve my issue(s). I realize that counseling can be beneficial for me and those who I am in a relationship, but it comes with no guarantees. While self disclosure of relevant information is beneficial to the counseling process, I also understand that counseling may involve discussing relationship, psychological, and/or emotional issues that may, at times, be distressing. I am aware of alternative treatment methods available to me.

My therapist will meet me with regularly, listen attentively, work with me to accomplish mutually stated and agreed upon goals. My therapist will treat me with respect and dignity. I understand that my therapist is bound by legal and ethical standards of his profession. This includes confidentiality, which means my therapist will not reveal any information about me except in the following situations:

- Medical Emergency
- Threats of suicide, bodily harm to self or others
- Suspected child abuse or neglect, suspected abuse of the elderly

I understand that I have the right to review my records at any time, and that if I have questions or concerns, I can reach out to my therapist through the contact information provided to me. In case of an emergency, I will call 911. Should my therapist become incapacitated, an authorized person will contact me and may refer me to another therapist. My records will continue to remain confidential unless otherwise authorized by me.

I have read, understood, and agree to the above.

_____ _____

Client Date

_____ _____

Parent/guardian if client is a minor Date

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