

Patient Contact Information & Policy for Counseling Sessions

Patient's Name _____ **DOB** _____

Address _____

City _____ **State** _____ **Zip** _____

Number where you can be contacted AM _____
PM _____

Who referred you? _____

Confidentiality: All information disclosed within sessions is confidential and will not be revealed to anyone with written permission except where disclosure is required by law. Disclosure may be required where there is reasonable suspicion of child or elder abuse, where there is reasonable suspicion that the client is likely to harm him or herself unless protective measures are taken or when required by the courts pursuant to a legal proceeding.

Routine Telephone Procedures: If you need to contact me between sessions, please leave a message with the receptionist or the appropriate voice mailbox. I attempt to return each message within 12 hours during the week and 24 hours on weekends and holidays.

Emergency Procedure: If an emergency situation arises and you are unable to contact myself, call 911 and/or proceed to the nearest emergency room or clinic.

Payments: Payment is due at the time of service. You will be given a receipt for you to submit to your insurance.

Cancellation: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours notice is required for rescheduling or canceling an appointment. Otherwise, the patient will be charged the full fee for that missed appointment.

I have read and understood these office policies.

Signature of Responsible Party

Date

If you are the patient:

I give full consent for myself for an evaluation and/or therapy until I notify Sue Watkins, LMFT of any changes or until she determines treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself.

Signature of Patient

Date

If your child is the patient:

I give full consent for my child, _____, for an evaluation and/or therapy until I notify Sue Watkins, LMFT of any changes or until she determines treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for my child.

Signature of Parent or Guardian

Date

Privacy Policy

I have read and understood the Privacy Policy for Therapy . I understand that I can review the Privacy Policy at anytime.

Printed Patient Name

Patient Signature

Date

Sue Watkins, LMFT 9303 Pinecroft Drive, Suite 200 The Woodlands, TX

