JANIE GARRETT, LCSW

(Please Print)

Today's date:	PCP:

CLIENT INFORMATION

REGISTRATION FORM

Client's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Client e mail:	Client contact telephone:

INSURANCE INFORMATION

(Please give your insurance card to the therapist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a client here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this client covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ [Insurance]				

Secondary insurance?	❑ [Insurance]		❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Janie Garrett, LCSW
INTAKE INFORMATION
BRIEF DESCRIPTION OF PRESENTING PROBLEM_____

BRIEF FAMILY HISTORY_____

CURRENT LIVING SITUATION (MARITAL STATUS, CHILDREN, ETC.)_____

WHAT YOU HOPE TO ACCOMPLISH IN PSYCHOTHERAPY_____

ANY ADDITIONAL ISSUES OF CONCERN OR PERTINENT INFORMATION_____

INFORMATION FOR CLIENTS: POLICIES, PROCEDURES AND PRIVACY PRACTICES

Janie Garrett, LCSW
Coppell Counseling Center
413 W. Bethel, Ste. 100

Coppell, Texas 75019
(972) 393-1596 ext. 33
Jogarrett@hotmail.com

STATEMENT OF UNDERSTANDING
Welcome to my practice! I appreciate the opportunity to work with you. Psychotherapy can take a significant commitment of time, effort and resources. It requires your active participation to change thoughts, feelings and behaviors. It is a process of introspection and growth. Therapy may at times be painful as you explore aspects of your history but this process may help free you from the past. During therapy sessions, I am actively engaged with my clients and invite you to discuss any issues of concern. If I believe that you might benefit by adjunctive or alternative treatment, I will facilitate referral.

MEETINGS AND FEES
My sessions are approximately 50 minutes in length. We typically begin with weekly sessions, moving to less frequency with recovery. My usual office fee is $100 and out of office fee is $150 per hour. I charge a contractual rate with several third party payors. It is your responsibility to verify insurance coverage, deductibles, copays and authorization for service but I will help in this process if necessary. Payment is due at time of service. There will be $100 charge for sessions not cancelled within 24 hours of session unless you have made other arrangements with me. Services will not resume until receipt of payment. I accept cash, checks and credit/debit cards.

CONTACTING ME
I do not take phone calls during sessions. You may contact me by leaving a message at (972) 393-1596 ext. 33 or e mail me at Jogarrett@hotmail.com or our website Coppell Counseling Center.com. Please note that if your telephone number is blocked, I may not be able to promptly return your call. Phone consultations will be billed at prorated office rate. When I am not available, a colleague will be on call for me. If you experience an emergency, please go to your nearest hospital emergency room or call 911.

CONFIDENTIALITY AND PRIVACY PRACTICES
I will protect the privacy of our conversations and records. I will not release records or speak to third parties without your express written consent. You may inspect records at any time. For clients under 17 years of age, parents or guardians must consent to treatment. I must have a copy of divorce or guardianship decrees which designate authorized representative of client before I can begin treatment of persons under 17 years of age. For any client who may be danger to self or others, I may contact appropriate entities.

PROFESSIONAL PROFILE
I am a Licensed Clinical Social Worker. I received my Masters Degree in Social Work at the University of Texas at Austin in 1977. I worked in public and private psychiatric settings before beginning my private practice in Coppell in 1988. I am married with a son and two step-children.

RECORDS SECURITY
Client records will be released to authorized entities only with your permission and this may be revoked at any time. Records may be released to legal authorities. In the event of my incapacity or death, your records will be managed by my business associate Kimberly Hatley, LPC.

COMPLAINT PROCEDURE
If dissatisfied with any aspect of our work together, I encourage you to discuss this with me. You may also file a complaint with the Texas State Board of Social Work Examiners at 1 800 942-5540.

AGREEMENT
I have read these policies, procedures and privacy practices and understand and agree to these as indicated by my signature. Consent is given for treatment but you may terminate treatment at any time.

_____ _____ _____

JANIE GARRETT, LCSW

APPOINTMENT REMINDERS AND ONLINE APPOINTMENT SCHEDULING

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: _____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Requested password: |__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Your email address: _____

Your cell phone number: _____

Your cell phone carrier (circle one):

Alltel AT&T Boost Mobile Nextel Sprint SunCom

T-mobile Verizon VoiceStream Virgin Mobile (Other) _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via a traditional telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.
(missed appointment fees will still apply)

Your appointment scheduling and reminders are part of your protected health information under HIPAA, so by signing this form, you are acknowledging your waiver of the right to privacy for that information.

Signature _____ Date_____

Coppell Counseling Center

413 W. Bethel Rd., Ste. 100 Coppell, Texas 75019
Phone: (972) 393-1596 Ext. 33 Fax: (972) 304-0400
Jogarrett@hotmail.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ Parent or authorized representative: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:
☐Mental health care information relating to the following treatment, condition, or dates: _____

_____

_____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient or authorized representative signature _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.