

**Atascocita Counseling Associates  
Krissy Cotten, MA, LPC**

**Adult New Client Profile**

Please complete the following as accurately and as completely as possible. Social Security Number is required only if you are filing with insurance.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ OK to Leave a Message? Y N

Work Phone: \_\_\_\_\_ OK to Leave a Message? Y N

Cell Phone: \_\_\_\_\_ OK to Leave a Message? Y N

Email: \_\_\_\_\_ OK to Send a Message? Y N

Employer: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's Address: \_\_\_\_\_ Employer \_\_\_\_\_

**In Case of Emergency, Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

How did you hear about my practice? \_\_\_\_\_

If you were referred by a person, may I have permission to thank them? Y N

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**Personal History:**

What is your marital status?

- Married
- Divorced
- Separated
- Single
- Dating

Do you have children, and if so, please list their ages?

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How many times have you been married? \_\_\_\_\_

Married \_\_\_\_\_ # of Years

**Educational History:**

Please check your highest level of education.

- High School
- College
- Graduate or Professional School

**Presenting Problem:**

What prompted you to seek counseling?

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How long has this been a significant concern for you?

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When did you first notice this problem?

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How has this problem affected you?

At home: \_\_\_\_\_

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At school/work: \_\_\_\_\_

Community: \_\_\_\_\_

Please check which of the following symptoms you have experienced:

- overeating
- recent weight loss
- recent weight gain
- recent appetite changes
- restlessness
- rapid heart rate
- anxiety
- fears/phobias
- muscle tension
- compulsive behaviors
- obsessions
- taking drugs
- drinking alcohol
- shortness of breath
- sweating
- vomiting
- stomach problems
- chest pain
- pain
- dizzy or lightheaded
- odd behavior/thoughts
- trembling or shaking
- difficulty concentrating
- distrust
- aggressive behavior
- outbursts of temper
- low motivation
- social withdrawal
- feelings of worthlessness
- depressed mood
- thoughts of hurting self or others
- crying
- easily distracted
- fatigue/loss of energy
- nightmares
- sleeping too much
- decreased need for sleep
- difficulty falling asleep
- difficulty staying asleep
- family emotional problems
- relationship problems
- housing problems

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- financial problems
- problems with school
- experienced a traumatic event
- hearing voices/seeing things
- other: \_\_\_\_\_

Have you ever intentionally harmed yourself? \_\_\_\_\_

Attempted suicide? \_\_\_\_\_

Harmed others? \_\_\_\_\_

**Psychiatric and Medical History:**

Please list any psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs).

Diagnosis	Length of Stay	Treatment	Response
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Please list any current or prior outpatient psychiatrists and therapists you have seen?

Name	Title	Location	How Long?
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Please list current **psychiatric** medications. Please attach a separate sheet if you need to list additional medication.

Name	Dosage	Duration	Response
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Please list current **non-psychiatric** medications.

Name	Dosage	Duration	Response

Please describe any significant medical illnesses or diagnoses:

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**Family History:**

Please check if there is any family history of the following:

- Depression
- Anxiety
- ADHD
- Bipolar (manic depressive)
- Schizophrenia
- Alcohol/Drug Problems
- Learning Disabilities
- Autism/Asperger/Pervasive Developmental Disorder
- Mental Retardation
- "Nervous Breakdown"
- Psychiatric Hospitalizations
- Suicide (or attempts)
- Panic Disorder
- PTSD (Post Traumatic Stress Disorder)
- OCD (Obsessive Compulsive Disorder)

**Personal Abuse History**

Have you ever been the victim of abuse or neglect?      Yes      No

If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical      Emotional      Neglect      Sexual      Witnessing violence

Other: \_\_\_\_\_

**Substance Use:**

Have you ever felt the need to cut down on your drinking?    Yes    No

Have you ever felt annoyed by criticism of your drinking?    Yes    No

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Have you ever felt guilty about your drinking?                      Yes      No

How many drinks (beer, wine, or hard liquor) do you consume each week, on average? \_\_\_\_\_

How much tobacco do you smoke or chew each week? \_\_\_\_\_

Have you ever used prescription medication for purposes it was not intended?  
\_\_\_\_\_

Have you ever used illegal drugs? \_\_\_\_\_

**Other:**

To what type of faith do you and/or your family adhere?  
\_\_\_\_\_

What are your favorite activities?  
\_\_\_\_\_

Who can you or family count on for support?  
\_\_\_\_\_

In the past, what has been helpful in dealing with your issues?  
\_\_\_\_\_

Is there anything else you feel is important for your therapist to know that we have not asked about on these forms?  
\_\_\_\_\_

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**Policies/Informed Consent**

Please read this agreement and sign at the end indicating that you understand and agree to the following. I would like to introduce these policies and procedures to you so that there are no misunderstandings in the future. Please ask any questions if you would like clarification or additional information.

1. I counsel primarily from the Adlerian perspective using supportive techniques. Its mission is to encourage the development of psychologically healthy and cooperative individuals, children, couples, and families in order to effectively pursue the ideals of social equality and democratic living. An optimistic and inspiring approach to psychotherapy, it balances the equally important needs for optimal development of the individual as well as social responsibility.
2. **Fees:** My fee for an individual 45-50 minute session is \$185. Payment is due at the time services are provided. Group therapy, when available, is \$50 per 45-50 minute group session.
3. There are fees associated with work provided outside of your therapy session. Telephone consultations that exceed 10 minutes are billed at a rate of \$3 per minute. Reports and letters generated at your request, and exceeding 10 minutes of work are \$75 per 30 minutes.
4. **Forensic Rates:** \$1500 for legal testimony or deposition; \$200 per hour (prorated) for local transportation, waiting, and preparation for legal testimony or deposition. Consultation with attorneys or litigants (in person or via phone), report writing, review of records, and any other service associated with a legal dispute will be billed at a rate of \$200 per hour (prorated). If I am subpoenaed or otherwise committed to appear in a legal case involving you, and the appearance is cancelled with less than 48 hours notice, you will be billed \$1500 to offset the cost of a lost day of my work. These rates are enforced whether you, or another litigant in a case involving you have compelled me to become involved. Failure to keep your account current may result in legal action or collection agency intervention.
5. Each session will be about 45-50 minutes in length. If you arrive late to your session, that time will be taken out of our meeting. I will consider you a "no show" if you have not arrived or called 15 minutes past our appointment time.
6. If you need to cancel or to reschedule an appointment, I require 24 hours advance notice. Cancellations made with less than the required 24 hours will be charged the full session fee for the missed appointment.

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7. Payment is due at the time of the visit unless you and I have made other arrangements. I accept cash, personal checks and debit cards. Returned checks are subject to an additional service charge of twenty dollars. As a courtesy, I will provide you with a statement which is necessary to file an insurance claim upon request. It is your responsibility to file and discuss any issues concerning your reimbursement with your insurance company.
8. You have the right to terminate our relationship at any time, for any reason.
9. Please give me seven (7) days' notice if you decide not to work with me anymore.
10. I also reserve the right to terminate our relationship, and will provide referrals to other therapists or health practitioners in that event.
11. Our discussions will remain confidential. The only exceptions to this rule are if you threaten to harm yourself or someone else, or in a response to court mandates. In these cases, I am required by law to report our conversation to the proper authorities.
12. I will strive to support you and/or family in the therapeutic journey as we work toward reaching set goals. Many clients do reach their goals, but I cannot guarantee this outcome.

**Acknowledgement and Consent**

By signing these polices, I

- (1) Acknowledge that I have been given a chance to review and ask questions about the *Policies and Practices to Protect the Privacy of Your Health Information*,
- (2) Understand that the counselors associated with Atascocita Counseling Associates are all sole practitioners and any legal action taken against one of the psychotherapists may not include the others.
- (3) Understand and agree to the stated practice polices as listed above and
- (4) Give full consent for myself or my minor child,

\_\_\_\_\_, to participate in psychotherapy/ counseling.  
I certify that I have the legal right to seek and authorize treatment for my minor child or myself.

\_\_\_\_\_  
Client Signature (or parent/guardian if client is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, hereby authorize and direct:

Name (individual, clinic, institution): \_\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

To provide to the office of Krissy Cotten, located at 18700 West Lake Houston Parkway, Suite 102, Humble, TX 77346, any and all medical records and/or additional and alternative information as noted below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By my initials, I provide authorization for Krissy Cotten, to disclose information to the above named: \_\_\_\_\_.

\*Disclosure may include records that have information regarding diagnosis and treatment of drug, alcohol, substance abuse, AIDS, or psychiatric disorders but is/are not limited to these areas. **To the party receiving this information:** This information has been disclosed to you from records whose confidentiality may be protected by Federal Law. If so, Federal regulations (42CFR, Part 2) prohibit you from and further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PRIVACY POLICY**

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996.

My Commitment to your privacy: I am required by law to maintain the confidentiality of your health information and must provide you with the following information:

The following circumstances may require me to disclose your health information:

- To public health authorities and health oversight agencies authorized by law to collect information.
- In response to a court administrative order in lawsuits or similar proceedings.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or health and safety of another individual or the public. I will disclose to a person or organization able to help prevent the threat.
- If you are a member of the U>S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security authorities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
- For Workers Compensation or similar programs.
- Your rights regarding your health information:
- You can request communication about your health and related issues in a particular manner or at a certain location. For instance, you may ask that I contact you at home, rather than work. I will accommodate reasonable requests.
- You can request restriction in my disclosure of your health insurance for treatment, payment, or operation. You can request that I restrict disclosure of health information to certain individuals. I am not required to agree to your request; however, if I do agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary for treatment.
- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including medical records and billing records, but excluding psychotherapy notes.

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- You may ask me to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for my practice. To request an amendment, request must be in writing and provide a reason that supports your request for amendment.
- You are entitled to receive a copy of this notice of privacy at anytime.
- If you believe your privacy rights have been violated, you may file a complaint with my practice or with the Secretary of the Department of Human Services.
- All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- I will obtain your written authorization for usage and disclosure of health information that are not identified by this notice, or permitted by law.

I hereby acknowledge that I have been presented with a Notice of Privacy Practice.

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Patient Printed Name

Patient Signature

Date

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Guardian Printed Name

Guardian Signature

Date

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**CREDIT CARD AUTHORIZATION FORM**

**Please Print**

Credit card billing information:		
Name:		
Email Address:		
Credit card type:	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	
Credit Card #:		
Enter cvc #:	For Visa and MasterCard, the last 3 digits on back of card: For American Express, the 4 digits on face of card:	
Expiration Date:		
Billing Address;		
City:		
State:		
Zip Code:		
Phone Number:		
Please complete following payment options:		
Dates of service:	Bill my credit card <u>each visit</u> for the following amount	\$
	Bill my credit card for <u>each missed</u> appointment for the following amount:	\$
I agree all information provided is accurate and complete. I also acknowledge services may be immediately terminated at Krissy Cotten, MA, LPC's discretion if any charges are declined or charge backs are claimed against any outstanding amount. Disputes to amounts should immediately be reported to Krissy Cotten, MA, LPC. Likewise, changes in the status of this card can also be reported to Krissy Cotten, MA, LPC.		
The undersigned is the dully-authorized representative of the above cardholder.		
Authorized Signature:		Date: