

Shawn Boggs Counseling

1000 Texan Trail, Suite 221
Grapevine, Texas 76051
Tel: 817.328.6139
www.shawnboggs.com

Client Information

Date: _____

Name: _____

Email: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Please circle where we may leave a message:

Home Work Cell Email

Address: _____

Date of Birth: _____

Sex: Please circle one:

Male Female

Marital Status: Please circle one:

Single In a Relationship Married Separated

Name of Spouse/Significant Other:

Children's Name(s) & Age(s): _____

Name of Primary Care Physician & City: _____

Name of Employer, City & Zip Code: _____

Emergency Contact

Name: _____

Phone Number: _____

Address: _____

Relationship: _____

Who referred you to Shawn Boggs Counseling? Please circle one:

Friend/Family Member Google Search Website Therapist/Doctor

Focus on the Family Church Referral Psychology Today Other

Highest level of completed Education: _____

Health Information

Please rate your health:

Very Good Good Average Declining

Recent Weight Changes: _____

Date of Last Physical: _____

Report from most recent exam: _____

Please list all important past or present injuries, illnesses or disabilities, regardless of severity:

Are you currently taking any medication?

Yes No

If Yes, please list them and their dosages: _____

Prescribed By: _____

Have you ever used drugs for other than prescribed medical purposes?

Yes No

If Yes, please list them: _____

Have you ever had a severe emotional upset? If so, please explain: _____

Have you ever terminated a pregnancy? If yes, what was its impact on you: _____

Have you ever had a miscarriage? If yes, what was its impact on you: _____

Religious / Faith Background

Current Faith involvement: _____

Please explain any recent changes in your spiritual life: _____

Other Information

Have you ever been arrested?

Yes No

Are you willing to complete and sign a release of information so your counselor may obtain social, psychiatric, or Medical information?

Yes No

Please Explain: _____

Have you recently suffered loss from serious personal, social, business, or other reversals?

Yes No

Please Explain: _____

Have you ever been the victim of a crime?

Yes No

If so, have you filed with Texas Crime Victims Compensation?

Yes No

Please identify any previous marriages: _____

Identify any history of psychiatric/emotional/drug or alcohol problems and treatments in your Current Family and in your Family of Origin: _____

Personality Information

Have you ever had counseling before?

Yes No

If Yes, describe the outcome: _____

Please list dates and names of counselor: _____

Have you ever been in a residential or outpatient program for chemical dependency or psychiatric treatment?

Yes No

Please circle all of the following words which best describe you now:

Active Ambitious Self-Confident Persistent Nervous Hardworking
Impatient Impulsive Moody Often-blue Excitable Imaginative Calm
Serious Easy-going Shy Good-natured Introvert Extrovert
Likable Leader Quiet Stubborn Submissive Lonely Self-conscious
Sad Fatigued Anxious Sensitive

Consent

Please read and circle accept or decline.

I have read and received a copy of CLIENT'S RIGHTS AND INFORMATION, and I understand the CANCELLATION policy.

Accept

Decline

I hereby consent for therapeutic services provided by Shawn Boggs Counseling, and I authorize Shawn Boggs Counseling to release information about me necessary to obtain insurance benefits and/or to receive payment.

Accept

Decline

I understand that my signature requests insurance payments to be made and authorize release of information necessary to pay the claim. Please Provide the Patient Signature Below.

Signature and Date:

I attest that I am the legal guardian or managing conservator of this minor child, with rights to consent medical treatment for this minor child and I do hereby consent for counseling services to be provided to this child.

Please Provide the Signature of Guardian or Managing Conservator Below.

Signature and Date:

Relationship:

Patient's Rights and Information

When you see Shawn D. Boggs, LMFT, for counseling you are buying a service. Therefore, you need helpful information to make a good decision. Below is important information about my business practices. Always feel free to ask questions for clarity on points that you feel unclear about.

I. SESSION FEE: My fee is \$175 for a 55 minute session. For those who using their Out of Network benefit with their insurance companies, follow this simple process. 1. Call the Customer Service phone number on the back of your insurance card, 2. Ask if you have Out of Network benefits for mental health. 3. If so, then ask what the deductible amount is to be met, what percentage of the visits is paid for, and the address to mail your receipt. You will mail the receipt I give you to your insurance company and they will refund the percentage of your visit in your plan.

II. CANCELLATION/ NO SHOW POLICY: Please be aware and understand that failure to call 24-hours in advance of a scheduled appointment will result in you being billed \$175, barring a reasonable emergency.

III. RECORDS & CONFIDENTIALITY: All of your communication becomes part of the clinical record, which is accessible to you in request. Your therapist will keep confidential anything that is communicated, with the following exceptions: a. you direct or give permission to tell someone else; b. your therapist determines that you are in danger to yourself or others; c. your therapist is ordered by the courts to disclose information; d. your therapist becomes aware of child abuse, elder abuse, or sexual impropriety by a doctor, minister, professional counselor, etc.

IV. DEPOSITIONS AND COURT APPEARANCES: If the therapist is subpoenaed to give deposition regarding the patient, the therapist will charge \$200 an hour. If the therapist is subpoenaed to give testimony in a court appearance, the therapist will charge a \$500 non-refundable retainer and \$200 an hour fee, portal to portal.

V. ABOUT COUNSELING: Counseling is a process that helps individuals, couples and families identify problems, establish goals, and identify pathways for achieving these goals. Counselors are trained to assist patients in changing troublesome and problem causing thoughts, feelings, behaviors, and relationships. Experience and research shows that patients who actively work on their problems both in counseling and outside, and take responsibility for changing their own thoughts, feelings, behaviors, and relationships are more likely to achieve their goals and receive more benefit from counseling than those who do not. As a patient you have the right to refuse to participate in treatment or to terminate treatment at your discretion.