

Personal Information

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Address: _____

City, State, Zip: _____ Referred by: _____

Parent/Guardian Name: _____

Address (if different): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Where would you like us to leave reminder messages: Home _____ Work _____ Cell Phone _____

If there is emergency at the office and we must contact you or cancel the appointment, where should we call:

In the event of an emergency with client/child, whom should we contact: Name: _____

Relationship: _____ Work # _____ Home # _____

Who Is Responsible for this account? Who is the insured?

Name: _____ Relationship to Patient: _____

Birthdate: _____ Soc. Sec. # _____

Address: _____

City, State, Zip: _____

Employer: _____ Occupation: _____

Work # _____ Home # _____ Cell # _____

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Kevin P. Glasser and/or Donica L. Jones the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him/her for services rendered and/or for cancelled or missed appointments.

Copy and/or any outstanding balance may be charged to my credit card (circle card): VISA MC AMEX DISCOVER

Card Number _____ Security Code _____ Expiration Date _____

X _____

If a Minor, Signature of Parent/Legal Guardian

Date

Please Provide A Copy of Your Insurance Card To Office Staff So Benefits May Be Verified. Thank You.

About Your Child's Education

Age: _____ Grade: _____ School: _____

Nick Names: _____ Failure or Held Back? _____

What do school teachers/personnel tell you about your child? _____

Grade	School	Avg. Grades	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

About Your Child's Family

Relatives	Name	Age/ Education	Does Child Get Along Well with Person?	Occupation
Father				
Mother				
Brother(s)				
Sister(s)				
Step-Father				
Step-Mother				
Step-Brother(s)				
Step-Sister(s)				
List all people who live in home with this child				

Transitions Counseling Center
11999 Katy Freeway #460
Houston, Texas 77079
Voice 281.597.9291 ❖ Fax 281.597.9761

Kevin P. Glasser, MA, LPC
Donica L. Jones, MA, LPC
Sandra P. Glasser, MEd, LPC

About Your Child's Routine

What kinds of physical exercise does your child get? _____

How much coffee, cola, tea, or other caffeine does your child consume each day _____

Is your child's eating restricted in any way? How? Why? _____

Bedtime: _____ Wake-up Time: _____ Hours of sleep on an average night: _____

Does your child have any problems getting enough sleep? _____ Please describe fully. _____

About Your Child's Health

Who is your child's pediatrician? _____ When was the last visit? _____

Any Concerns shared by the doctor? _____

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

Describe any allergies your child has: _____

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please _____

List all prior counselors/dates/reasons: _____

Anything else you are concerned about? _____

These Questions are regarding older children.

Is this child in a gang? _____. Has this child used drugs? _____. If so, describe which drugs, frequency, age at first use, and amounts _____

Has this child ever been pregnant or fathered a child? _____. If yes, please tell what happened with each pregnancy: _____

Agreement for Therapy with a Minor:

❖ I, _____, the parent/legal guardian of the minor, _____, give my permission for this minor to receive therapeutic services provided through

Transitions Counseling Center (Kevin P. Glasser, MA, LPC, Donica L. Jones, MA, LPC, and Sandra P. Glasser, MEd, LPC).

❖ I have read, understand, and signed the informed consent related to my child's therapist and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his or her family.

❖ Furthermore, I understand that I am expected to participate in this process by meeting with the therapist at least once per month while my child is in therapy.

❖ My signature below means that I understand and agree with all of the points above.

Signature of Parent/Guardian

Date

About Your Child's Symptoms

Please mark all of the items that apply to your child. Feel free to explain or to add any others.

Accident Prone	Hitting	Procrastinates
Affectionate	Hostile	Provokes Others
Aggressive	Hyperactive	Rages
Argues	Hypochondriac	Recent Move
Assaults	Imaginary Playmates	Refuses
Bathroom Language	Immature	Relationships with Friends
Bigoted	Inappropriate Sexual Behaviors	Relationships with Siblings
Bossy to Others	Inattentive	Relationships with Teachers
Breaks Rules	Independent	Resists
Breaks the Law	Inflicts Pain on Others	Responsible
Bullied by Others	Insults Others	Restless
Bullies Others	Interrupts	Rocking Motion/Behavior
Cheats	Intimidated by Others	Repetitive Movements
Clowns Around	Intimidates Others	Runs Away
Competition	Intolerant	Sad
Complains	Irritability	School Avoiding
Complains of Feeling Sick	Isolates	Self-harming Behaviors
Compliant	Lacks Organization	Sexual Preoccupation
Concern for Others	Lacks Respect for Authority	Sexually Active
Conflicts at School	Learning Disability	Shy
Conflicts at Home	Legal Difficulties	Slow Moving
Conflicts with Friends	Lethargic	Slow Responding
Conflicts with Police	Likes to be Alone	Smart-alecky
Cries Easily	Loitering	Smoking
Cruel to Animals	Loss of Friends	Social
Dares Others	Low-Frustration Tolerance	Speech Difficulties
Dawdles	Lying	Stealing
Daydreams	Manipulates	Stubborn
Defiant	Masturbation	Suicide Talk or Attempt
Dependent	Mental Retardation	Swearing
Destructive	Moody	Talks Back
Developmental Delays	Mute – Refuses to Speak	Teased
Difficulties with Parents	Nail Biting	Teases Others
Disobedient	Name Calling	Temper-tantrums
Disrupts Family Activities	Needs High Supervision	Threatens
Distractible	Negativism	Thumb sucking
Dropping Out of School	Nervous	Tics – movements or noises
Drug or Alcohol Use	New School	Timid
Drug Sales	Nightmares	Truancy
Eating Issues	Noisy	Uncooperative
Failure in School	Noncompliant	Uncoordinated
Fantasy Life	Obedient	Under-active
Fearful	Obesity	Unhappy
Feelings Are Easily Hurt	Only Younger Playmates	Unprepared
Fidgety	Oppositional	Vandalism
Fighting	Outgoing	Violent
Finger Sucking	Out-of- Seat Behaviors	Wastes Time
Fire Starting	Overactive	Wetting/Soiling of Bed/Clothes
Fire Setting	Picks on Others	Withdraws
Friendly	Poor Concentration	Work Problems
Hair Chewing	Pouts	Yells
Head Banging	Prejudiced	

About Kevin P. Glasser, MA, LPC, Donica L. Jones, MA, LPC, and Sandra P. Glasser, MEd, LPC

- ❖ I understand that each counselor is a Licensed Professional Counselor in the state of Texas and each counselor has earned a Master of Arts in Psychology or a Master of Educational Counseling degree.
- ❖ I understand that each counselor works with children, adolescents, and adults in individual and family counseling settings.
- ❖ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed with that assignment.
- ❖ I understand that if I am concerned about slow progress or lack of progress I have the right to speak about my concerns.
- ❖ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- ❖ I understand that there are some occasions when confidentiality can/must be breached. These are: a) I sign a Release of Information Form or I verbally direct my counselor to tell someone else, b) My counselor determines that his/her client poses a threat to self or others, c) My counselor is ordered by a court to disclose information, d) My counselor suspects child abuse has taken place and will notify Child Protective Services, or e) Forensic consultation or treatment ordered by the courts.
- ❖ I understand that counseling can improve as well as upset the equilibrium in any person or family.
- ❖ I understand that if I have a complaint I cannot resolve with my counselor and I wish to file a formal complaint I may contact the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.
- ❖ I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay.
- ❖ I understand that there is a returned check fee of \$25.00 and that if a returned check is not cleared up in 30 days my counselor will file a suit with the Harris County District Attorney's Office.
- ❖ I understand that sessions are 45-minutes in duration, cost \$125.00, and that all co-pays are due at the time of service.
- ❖ I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of \$60.00 and it will be debited from my credit card.
- ❖ I understand that Kevin Glasser, Donica Jones, and Sandra Glasser are not psychiatrists, they are Master's level therapists, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medical evaluation.

By signing below I confirm that I have read agree to and received the above information:

If a Minor, Signature of Parent/Guardian of Client

Date Received and Read

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Acknowledgement of Receipt of Notice of Privacy Practices for

Transitions Counseling Center (Kevin P. Glasser, Donica L. Jones, and Sandra P. Glasser)

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

Patient: _____ Date: _____

(If a Minor, Signature of Parent/Guardian)

Consent for Use and Disclosure of Health Information

I hereby permit Transitions Counseling Center (Kevin P. Glasser, MA, LPC, Donica L. Jones, MA, LPC, and/or Sandra P. Glasser, MEd, LPC) to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

Patient Signature: _____ Date Signed: _____

(If a Minor, Signature of Parent/Guardian)

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent.
Your treatment by this office is conditional on your signing this consent.

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THIS IS YOUR COPY TO KEEP

Notice of Privacy Practices

Transitions Counseling Center
Kevin P. Glasser, MA, LPC, Donica L. Jones, MA, LPC, and Sandra P. Glasser, MEd, LPC
Houston, Texas

This notice describes how medical information about you may be used and disclosed

and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services. You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of May 1, 2005.

THIS IS YOUR COPY TO KEEP