

### Patient's Personal Information

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_

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

City, State, Zip: \_\_\_\_\_ Referred by: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

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 you, 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, LPC, 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 for services rendered and/or for cancelled or missed appointments.

Copay 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 \_\_\_\_\_

Signature of patient or parent if minor

Date

**Please Provide Your Insurance Card to Office Staff for Verification of Benefits. Thank you.**

### ALL ABOUT HER

Name: \_\_\_\_\_  
 Where did you attend public school? \_\_\_\_\_  
 Did you attend college? When, where? \_\_\_\_\_  
 Any plans to further your education? \_\_\_\_\_ If so, when and what? \_\_\_\_\_

### About Her Relationships

Please list your marriage(s) or other important "significant-other" relationships

	Spouse's name Or Significant Other	Year Begun	Year Ended	Married to this person?	Children from this relationship and their ages
#1					
#2					
#3					
Please list all people who currently live with you					

### About Her Family

Relative	Name	Good Relationship?	Current age, or age at death	Occupation	Favorite Times Together/Memories
Father					
Mother					
Brother(s)					
Sister(s)					
Any other significant person?					

### ALL ABOUT HER

About Her Health:

Who is your Doctor? \_\_\_\_\_ Last Visit: \_\_\_\_\_

Concerns? \_\_\_\_\_  
\_\_\_\_\_

Do you have any chronic medical concerns? \_\_\_\_\_ If so, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all medications or drugs (legal or illegal) you take or have taken in the last year:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ABOUT HER CONCERNS**

Please check all of the items below that you currently experience or are having difficulty, and feel free to add any others at the bottom under "Other concerns or issues." You may add details as needed to clarify.

Abuse – emotional	Impulsive spending	Self abuse – burning
Abuse – neglect	Impulsiveness	Self abuse – cutting
Abuse – physical	Indecision	Self abuse – other
Abuse – sexual	Inferiority feelings	Self abuse – scratching
Aggression	Inhibitions	Self-centeredness
Anger	Interpersonal conflicts	Self-control
Anxiety	Irresponsibility	Self-esteem
Arguing	Irritability	Self-neglect
Attention Problems	Judgment problems	Separation
Career Concerns	Laziness	Sexual conflicts
Childhood Issues	Legal matters	Sexual desire differences
Children – care of	Loneliness	Sexual dysfunctions
Children – custody	Loss of control	Sexual – other issues
Children - management	Losses	Shyness
Choices I have made	Low energy	Sleep – insomnia
Codependence	Low frustration tolerance	Sleep – nightmares
Compulsive spending	Low income	Sleep – too little
Concentration problems	Low mood	Sleep – too much
Confusion	Marital coldness	Step-parenting
Crying	Marital conflict	Stress
Deaths	Marital distance	Stress-management
Debt	Marital infidelity/affairs	Suicidal thoughts
Decision making	Medical concerns	Suspiciousness
Delusions – false ideas	Memory problems	Temper problems
Dependence	Menopause	Tension/stress
Depression	Menstrual problems	Thought disorganization
Distractibility	Mixed feelings	Threats of violence
Divorce	Mood swings	Tiredness
Drug abuse – over the counter	Motivation	Tobacco use
Drug abuse – prescription	Mourning	Violence
Drug abuse – street drugs	Obsessions	Violence – victim of crime
Drug abuse – alcohol	Outbursts	Work problems
Eating – poor appetite	Oversensitive to criticism	Weight and diet issues
Eating – making myself vomit	Oversensitive to rejection	Withdrawal – isolating
Eating – overeating	Panic or anxiety attacks	Employment problems
Eating – under-eating	Parenting	Employment – lack of
Emptiness	Perfectionism	Employment – overdoing
Failure	Pessimism	Employment – termination
Fatigue	Phobias	Other Concerns or Issues:
Fears	Physical problems	
Financial troubles	PMS	
Friendship problems	Poor self-care	
Gambling	Procrastination	
Goals not being met	Relationship problems	
Grieving	Relaxation	
Guilt	Re-marriage	
Headaches, pains	Risk taking	
Health	Sadness	
Hostility	School problems	

### ALL ABOUT HIM

Name: \_\_\_\_\_  
 Where did you attend public school? \_\_\_\_\_  
 Did you attend college? When, where? \_\_\_\_\_  
 Any plans to further your education? \_\_\_\_\_ If so, when and what? \_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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

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

**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:**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

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

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: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

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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## 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.

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