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ter Blvd
Suite 200
Sugar Land, TX 77478
Office: 281-494-9100
Fax: 281-494-9115
terri.lively@comcast.net

Sugar Creek Psychotherapy
Terri Lively, LCSW

www.sugarcreekpsychotherapy.com

Scheduling: 832-895-0072 or
scheduling@sugarcreekpsychotherapy.com

Consent for Services

I request that Terri Lively, LCSW provide psychotherapy services to me and if applicable to my minor children.

I agree to pay fees for services on the day the services are rendered.

☐ Fees will by paid by my health care plan except for co-insurance, co-pay, or deductible amounts and services not covered by my health care plan.

OR

☐ I will not be using health care coverage and will pay a fee of $150 per session.

My copay or agreed fee for service amount is _____ per session.

If I have a deductible to meet first, I agree to pay _____ per session until my deductible is met.

I agree to pay for any and all missed appointments unless I provide notice of cancellation at least 24 hours in advance. The charge for each missed appointment cancelled within a 24 hour period is $75.00. I understand that insurance companies do not pay for missed appointments.

I understand that Sugar Creek Psychotherapy will do their best to obtain accurate information from my insurance company regarding my coverage, and that they have no control over incorrect information that may be provided by my insurance company. I agree that I, as the client or minor client's parent, am ultimately responsible for any unpaid fees.

I have read this consent for services and agree to these terms.

_____
Client Signature

_____
Parent/Conservator's Signature (If client is a minor)

_____
Date

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Consent to Use and Disclose Your Health Information

This form is an agreement between you _____ and Sugar Creek Psychotherapy. When the word "you" is used below, it will mean your child or other person if you have written his or her name here _____.

In order to diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We may need to use this information to decide what treatment is best for you and be able to provide that treatment. We may need to share this information with your doctor or another health professional that provides treatment to you. Your insurance company has the right to contact us to ask questions about your treatment.

In a non-emergency situation, Terri will talk to you about who she will share your information with and why.

By signing this form, you are agreeing to let us use your information here and send it to the above noted others.

You have the right to request that we do not use or share some of your information for treatment, payment, or administrative purposes by notifying us in writing. Although we will try to respect and comply with your wishes, we are not required to agree to these limitations.

If you do not sign this Consent, we cannot treat you.

In the future we may change how we use and share your information or we may change our Notice of Privacy Practices. If we do, you can get a copy by calling us at 281-494-9100.

After you have signed this consent, you have the right to revoke it by writing a letter telling us you no longer consent and we will comply with your wishes from that time on. However, if we have already used or shared some of your information, that cannot be changed.

Signature of client or his/her personal representative	Date
Printed name of client or personal representative	Relationship to client
Description of personal representative's authority	

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Confidential Information Sheet

Date: _____

Name	_____ Last	_____ First	_____ MI	Home Phone	_____
				Work Phone	_____
Address	_____ Street	_____ City	_____ State	Cell Phone	_____
			_____ ZIP	Email	_____

Please **DO NOT** contact me by (check all that apply)	☐ Home Phone	☐ Work Phone	☐ Cell Phone	☐ Email
My preferred method of contact is	☐ Home Phone	☐ Work Phone	☐ Cell Phone	☐ Email

Age	_____	Marital Status	☐ Single	☐ Separated	☐ Widowed
Birthdate	_____		☐ Married	☐ Cohabitated	☐ Divorced
Social Security #	_____				

Are you currently employed?	☐ Yes	☐ No						Occupation	_____		
Company Name	_____										
Education: Check Highest Level Completed	High School				College				Post Graduate		
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 1	☐ 2	☐ 3	☐ 4	☐ 1	☐ 2	☐ 3	☐ 4

Spouse's Name	_____							Occupation	_____		
Age	_____							Years Married	_____		
Birthdate	_____										
Social Security #	_____										
Education: Check Highest Level Completed	High School				College				Post Graduate		
	☐ 1	☐ 2	☐ 3	☐ 4	☐ 1	☐ 2	☐ 3	☐ 4	☐ 1	☐ 2	☐ 3	☐ 4

Your Prior Marriages	Spouse's Prior Marriages
From _____ To _____	From _____ To _____
From _____ To _____	From _____ To _____
From _____ To _____	From _____ To _____

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Confidential Information Sheet (continued)

Who referred you to Terri?	Name	Relationship	May Terri thank this person for the referral? **Y/N**
Person to Contact in Emergency	Name	Relationship	Phone #

What issues brought you to therapy today? _____

What are your goals through psychotherapy? _____

Have you ever been in psychotherapy? ☐ Yes ☐ No

If yes, with whom and when? _____

Was it helpful? _____

Have you ever been hospitalized for a mental or emotional problem? ☐ Yes ☐ No

If yes, where and when? _____

List any medications you are taking: _____

Who prescribed these medications? _____

Do you have any significant physical problems? ☐ Yes ☐ No

If yes, what are the problems? _____

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Family History

Where did you grow up?

_____

	Mother	Father
Living or deceased?	☐ Living ☐ Deceased	☐ Living ☐ Deceased
If living, how old? If deceased, when did he/she die?	_____	_____
Quality of relationship	☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list the names and ages of brothers and sisters and rate the quality of your relationship with each:

Name	Age	Quality of Relationship
_____	_____	☐ Excellent ☐ Good ☐ Fair ☐ Poor
_____	_____	☐ Excellent ☐ Good ☐ Fair ☐ Poor
_____	_____	☐ Excellent ☐ Good ☐ Fair ☐ Poor
_____	_____	☐ Excellent ☐ Good ☐ Fair ☐ Poor

If you have children, please list names and ages of each:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Is there any history of mental or emotional problems in your immediate or extended family?

_____

Is there any history of drug or alcohol addiction or abuse in your family?

_____

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Patient Insurance Information

Insurance Company		ID or Member #	
Phone # of Insurance Company		Group #	
Address of Insurance Company	Street	City	State ZIP

Patient's relationship to Insured		Full time student? ☐ Yes ☐ No	
Primary Insured Name			
Primary Insured Address	Street	City	State ZIP
Primary Insured SS#			
Primary Insured Employer			

Release of Information and assignment of benefits

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the therapist who accepts assignment for services.

Signed: _____ Date: _____

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