

**Kim Ferren, LPC**  
**2850 Shoreline Trail Suite 102**  
**Rockwall, Texas 75032**  
**(972) 679-1622**

**Please fill out this form as completely as possible for your intake visit.**

Date \_\_\_\_\_

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_

Employer's Address \_\_\_\_\_

Work Phone \_\_\_\_\_ Permission to call at work? Yes \_\_\_ No \_\_\_

Referred to this office by \_\_\_\_\_

Are you currently seeing any other mental health professional (psychiatrist, counselor, therapist, social worker, etc.)? If so, please list. \_\_\_\_\_  
\_\_\_\_\_

Family Doctor \_\_\_\_\_

Are you taking any medication at this time? If so, please list. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently using any community resources (twelve step program, WIC, etc.)? If so, please list. \_\_\_\_\_  
\_\_\_\_\_

**Information Concerning You and Your Family**

Marital Status \_\_\_\_\_

If married, spouse's name \_\_\_\_\_ Number of Years Married \_\_\_\_\_

Spouse's Age \_\_\_\_\_ Spouse's Place of Employment \_\_\_\_\_

If you are divorced, please list the names of previous spouse(s) and the number of years divorced \_\_\_\_\_

Please list names and ages of children:

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Has anyone in your family had counseling before? If so, who and for what reason?

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Briefly describe what brings you to counseling now? \_\_\_\_\_

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Who are the people in your life who mean the most to you? \_\_\_\_\_

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What is important to you? \_\_\_\_\_

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If you have a problem, who are you most likely to share it with? \_\_\_\_\_

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With whom do you enjoy spending time? \_\_\_\_\_

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What are your interests? \_\_\_\_\_

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What are your plans for the future? \_\_\_\_\_

\_\_\_\_\_

Of what accomplishment are you are most proud ? \_\_\_\_\_

\_\_\_\_\_

Do you use alcohol or drugs? If so, please describe \_\_\_\_\_

\_\_\_\_\_

Have you ever experienced sexual difficulties? If so, Please explain. \_\_\_\_\_

\_\_\_\_\_

**Information Concerning You and Your Family Origin:**

Describe your relationship with your parents (step-parents, if applicable), both currently and in the past.

Past

Present

Mother \_\_\_\_\_

Father \_\_\_\_\_

Step mother \_\_\_\_\_

Step father \_\_\_\_\_

Please list your siblings and their ages:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there a history of drug or alcohol abuse in your family? If so, please describe.

\_\_\_\_\_

Is there a history of sexual abuse in your family? If so, please describe.

Is there a history of physical abuse in your family? If so, please describe.

**Consent for Requesting Records:**

If you would like for me to send for additional information, counseling records, or medical records, please fill in the information below:

To (your doctor or counselor)

Name

Address

Phone Number

Fax Number

Please send my medical/counseling records to:

Kim Ferren, LPC  
PO Box 736  
Fate, Texas 75132  
(972) 679-1622

Signature

Date

## Consent to Treatment

I, Kim Ferren, am committed to providing high quality services to my clients and to providing them with all of the information necessary to be informed about the treatment process. As part of my effort in this regard, I am providing the following information about legal and ethical issues. If you agree to these stipulations, please sign the last page of this form. Please feel free to discuss this with Kim Ferren before signing the consent.

1. **Confidentiality:** I am committed to confidentiality to the fullest extent by Texas law. There are several exceptions, the following are common: 1) Any evidence of child abuse (past or present) must be reported. 2) If an individual intends to take harmful, dangerous, or criminal actions against another human being or against him/herself, it is my duty to report such action or intent to authorities. 3) Sexual improprieties by a former therapist are a criminal offense and must be reported. (You have certain rights in such reporting which your therapist can explain to you.) 4) Certain court orders/actions such as custody cases, malpractice actions, criminal cases, etc. 5) Collection of fees: If you have questions about this area, please feel free to discuss it with me.
2. **Fees and insurance:** My standard fee is \$150.00 for the initial visit and \$125.00 per 45-50-minute session. Some insurance companies may cover part of this cost. If you have coverage, you are welcome to assign the benefits and pay only your co-pay portion at the time of each visit. If your policy deductible has not been met, you are responsible for paying that amount. **By law, I am not allowed to waive deductible or co-payments.**

By consenting to treatment, you acknowledge that you are responsible for the cost of these provided services (to you or your minor child) and agree to pay them when billed or at the time of services. If services are not paid, then you agree to pay a service charge within 30 days notice. After 60 days the account may be assigned to an outside agency, in which case you will be responsible for paying attorney fees and/or collection fees and expenses.

It is important to remember that if you choose to utilize your insurance, I will be obligated to provide them certain information about your case including (but not necessarily limited to) a diagnosis, type and dates of service. By assigning benefits to me (Kim Ferren) you are authorizing me to provide your insurance carrier (or their intermediary) whatever information is necessary to process the claim. If you choose to utilize your insurance, it may affect your insurability. If at any time you have questions about the fees or insurance, please feel free to discuss it with me.

3. **Appointments:** If you need to cancel an appointment, 24-hours notice is required. If you miss an appointment without sufficient notification, you will be charged. Missed appointments CANNOT be filed with insurance. Therefore, you are responsible for ½ the entire fee.
4. **Right to withdraw from treatment.** If a conflict arises for the client or the therapist, either has the right to withdraw from the treatment process. If the therapist feels the need to withdraw from providing treatment, he/she will so inform the client and provide appropriate referrals.
5. If legal actions occur in which I am requested or subpoenaed to provide testimony (such as in a custody case) you will be responsible to provide the following even if the subpoena is sent from the opposing side of the case: 1) travel expenses, 2) hourly or per diem fees based on my existing fees, from the time I leave the office until I return. At

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Notice of Privacy Practices-HIPPA

This document contains important summary information about the Health Insurance Portability and Accountability Act (HIPPA), a new federal law that provides new privacy protections and new patient rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPPA and its application to your personal health information in greater detail. This notice is posted in the lobby for your convenience. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session.

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Name

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Date

least 50% of the anticipated cost will be expected prior to the court appearance. Record copying fees begin at \$25.00.

6. In the unlikely event that I, in my clinical judgment, believe you to be dangerous to yourself or someone else, by signing the consent you authorize me to contact either the persons listed as your emergency contacts, or someone else to provide assistance through the crisis situation.
7. The services I provide as a therapist will include an assessment phase, a treatment phase, and a termination phase as part of the process of clinical psychotherapy. Ours will be a strictly professional relationship with clear professional boundaries.
8. In an emergency situation, you are encouraged to call 911, go to your nearest emergency room, or call the Suicide and Crisis Center at any time at 214/828-1000. Non-emergency phone calls to my office will be returned by the following business day.

***If you have read and understand these aspects of consent, please sign below. Feel free to take a copy of the consent if you wish. If you have questions about any of the information on this form, discuss them with me and wait to sign the form with me. I am looking forward to working with you.***

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Signature

Date

ANY PROBLEMS REGARDING ETHICAL QUESTIONS AND/OR CONCERNS MAY BE DIRECTED TO THE FOLLOWING CONSUMER HOTLINE: 1-800-942-5540