Donald L. Camp, M.A.

1701 N Collins Blvd., Suite #218
Richardson, Tx, 75080

Patient Name:_____	Social Security #:_____	Birth Date:_____
Spouse's (if married) Name :_____	Social Security #:_____	Birth Date:_____
Father's (if a minor) Name:_____	Social Security #:_____	Birth Date:_____
Mother's (if a minor) Name:_____	Social Security #:_____	Birth Date:_____

Home Address:_____ City:_____ Zip:_____

Primary Phone #:_____ Who referred you?_____

Employment Information

Insured's Name:_____ Work Phone:_____

Insured's Employer:_____ May you be called at work?_____

Job Title: _____

Spouse Information (if married)

Spouse's Name:_____ Work Phone:_____

Spouse's Employer:_____ May you be called at work?_____

Job Title: _____

Insurance Information

Insurance Carrier:_____

Address:_____ City:_____ State:____ Zip:_____

Group Number:_____ Certificate or ID #: _____

Assignment of Medical Benefits (if applicable)

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Private Carrier and all other health plans to: **DONALD L. Camp, M.A, LPC, LMFT**. This assignment shall remain in effect until revoked, by me, in writing. A photocopy of this is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment.

Print Name:_____ Date:_____

Signed: _____ Date:_____

Please list all children:

Name:	Age, Grade, Sex:	His/Hers/Ours:	Living at home?

Please answer the following questions:

1. Have you ever been in counseling before? _____ If yes, when?_____
   What type? (family, marital, group, individual)_____
2. What type of counseling are you seeking at this time?_____
3. Is the patient taking any medication to help with depression, anxiety, etc., or medicine that might affect their mood? _____ If yes, what medications and why? _____
4. Does the patient suffer from any allergies including allergies to any medications?_____
   If yes, what are the allergies? _____
5. Does the patient use alcohol, drugs, or tobacco in any form?_____ If yes, what substances?
   When was the last time? How frequent?_____
6. Briefly state your reason for for seeking counseling and what you want to accomplish in counseling

Patient's Informed Consent for Treatment

I have chosen to receive counseling services from **Donald L. Camp, M.A., LPC, LMFT**. My choice is voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because therapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which can be upsetting m nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that if I am utilizing health benefits I may be contacted by the insurer to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

I understand that it is my responsibility to cancel any appointment that I can not attend at least 24 hours in advance of the scheduled time or I may be subject to charges of 50% of my usual fee. (insurance will not reimburse for missed appointments.)

I understand that I have basic rights as an individual seeking counseling services. These rights include, but are not limited to, the following:

1. The right to be informed of the various steps and activities involved in receiving counseling services.
2. The right to confidentiality under federal and state laws relating to the receipt of counseling services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that in some circumstances my therapist may need to exchange information with my primary care physician and that such exchange of information will only take place with my separate, written consent. If I am utilizing health care benefits my therapist may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I acknowledge that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid or as provided in my particular benefit plan. **I have read and understand the above.**

Patient Signature: _____ Date: _____

Parent, guardian, or conservator Signature: _____ Date: _____

Witness Signature: _____ Date: _____