DON HAYS, Ph.D.

16800 Dallas Parkway, Suite 150
Dallas, Texas 75248 214-505-6520 CP

PATIENT NAME :_____ SOCIAL SECURITY # _____ BIRTH DATE : _____
SPOUSE'S **(If Patient is Married)** NAME :_____ SOCIAL SECURITY # _____ BIRTH DATE : _____

ONLY FILL IN FATHER AND MOTHER'S NAME IF PATIENT IS A CHILD OR ADOLESCENT

FATHER'S **(If Patient is a Minor)** NAME :_____ SOCIAL SECURITY # _____ BIRTH DATE : _____
MOTHER'S **(If Patient is a Minor)** NAME :_____ SOCIAL SECURITY # _____ BIRTH DATE : _____

HOME ADDRESS :_____ CITY : _____ ZIP: _____
HOME TELEPHONE :_____
CELL PHONE: _____ **WHO REFERRED YOU ?**_____
EMPLOYMENT INFORMATION : _____
INSURED'S NAME : _____ INSURED'S BIRTH DATE: _____
May You Be Contacted At Work? _____
INSURED'S EMPLOYER : _____ WORK PHONE: _____
INSURED'S ADDRESS IF DIFFERENT FROM PATIENT'S: _____
JOB TITLE :_____ _____

SPOUSE'S **(Of Insured)**
NAME : _____ WORK TELEPHONE : _____
May You Be Contacted
SPOUSE'S EMPLOYER : _____ At Work If Necessary?_____
JOB TITLE : _____

INSURANCE INFORMATION :
INSURANCE CARRIER :_____
ADDRESS :_____ CITY :_____ STATE :____ ZIP :_____
GROUP NUMBER :_____ CERTIFICATE OR ID # _____
CERTIFICATION OR AUTORIZATION NUMBER (If Applicable): _____
INSURANCE MEMBER SERVICE PHONE NUMBER: _____

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 other health plans to : **DON HAYS, Ph.D., 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.

SIGNED : _____ DATE :

Don Hays, Ph.D.
Licensed Professional Counselor and Licensed Marriage and Family Therapist
Client Information and Consent for Treatment

Welcome to my practice. I look forward to working with you regarding your concerns.
Qualifications: I have a Ph.D. in counseling and am licensed as a professional counselor and as a marriage and family therapist.. I have been in practice for 18 years and have extensive experience working with individuals, couples and families.

Orientation: I have experience in family systems, reality therapy and solution-oriented therapy and will use several techniques to help you clarify your goals for change and to begin taking steps to improve your life. I believe all people were created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth.

Nature of Counseling: The purpose of counseling may include relieving distress; decreasing of a mental or emotional disorder; improving one's mood, self-esteem, or overall well-being; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. Counseling requires your active participation in identifying problems and goals and working to make changes. I will work to provide a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable.

Effects of Counseling: While benefits are expected from counseling, specific results are not guaranteed. Counseling at times involves unpleasant feelings and addressing issues that may be difficult. Some life changes can be temporarily distressing. Together we will work to achieve the best results for you.

Client Rights: Some individuals only need a few sessions to achieve their goals; others may require months or even longer. You have the right to discontinue our professional relationship at any time. You have the right to refuse any recommendation I make. You have the right to humane care and protection from harm, abuse or neglect. My services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns to your satisfaction, you may report your complaints to the State Board of Examiners of Professional Counselors at 512-834-6658.

Referrals: If at any time you or I believe a referral is needed, I will provide recommendations for other providers or programs to assist you. You will be responsible for contacting and evaluating those referrals.

Fees: Counseling sessions are billed at $100 per 45-50 minute session. If you are using insurance benefits, you are usually only responsible for the copay unless there is an unmet deductible. For legal proceedings that require my participation, I bill $175 per hour (includes depositions, time spent waiting to testify, driving time, etc.). Other services for which fees apply are letters or documents for employment, disability, or legal purposes and photocopying, mailing or faxing medical records to other providers, attorneys or insurance companies.

CANCELLED, MISSED OR RESCHEDULED APPOINTMENTS
I WILL NEED TO BILL YOU FOR ANY SCHEDULE CHANGES WITH LESS THAN 24 HRS NOTICE AS YOUR INSURANCE WILL NOT PAY FOR A MISSED OR CANCELLED APPT

Cancellation: If you miss a scheduled appointment or call to change an appointment time on the same day that you are scheduled to see me, I cannot bill your insurance for the hour time slot that you have reserved with me but did not attend. **Your Insurance carrier will not pay for scheduled appointment that you either miss or for an appointment that you call me to cancel or to change on the day of the appointment.** This does not give me adequate time to call another client to fill the time slot so I will need to bill you for **THE FULL FEE—NOT JUST YOUR COPAY** for the missed appointment or an appointment that is changed on the same day as the appointment. I want to be clear about this because this happens frequently. If you are sick or injured, this is an exception but not working late, company meetings, or soccer practice. INITAIL HERE: _____ DATE:_____

Don Hays, Ph.D., LPC
Licensed Professional Counselor and Licensed Marriage and Family Therapist

Records and Confidentiality: All of our communication becomes part of your clinical record. Adult records are disposed of seven years after the file is closed. Records for minors are disposed of seven years after the child's 18th birthday.

Your files are kept secure and confidential with the following exceptions:

1. You are at risk of imminent serious harm to yourself or others.
2. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person.
3. You disclose sexual misconduct by a physician or therapist.
4. I am ordered by a court to disclose information (e.g. child custody suits)
5. You direct me to release your records
6. Information is requested by your insurance company for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes.

I give consent for Don Hays, Ph.D., LPC to provide counseling services to me. I understand that no guarantees have been made as to the results of the treatment authorized.

Client Signature_____ Date_____
2nd Client Signature_____ Date_____
Parent/Guardian_____ Date_____

Consent to Release Confidential Information

This authorizes Don Hays, Ph.D., LPC to disclose information concerning
Client Name_____ to the following:

____Insurance Company
____Psychiatrist_____
____Primary Care Physician_____
____Other_____
____Other_____

The purpose of this disclosure is:
____Authorization/Utilization Review
____Coordination of Care
____Payment/Billing

Client Signature_____ Date_____
2nd Client Signature_____ Date_____
Parent/Guardian_____ Date_____

Don Hays, Ph.D., LPC
16800 Dallas Pkwy, Ste 150. Dallas, TX 75248
214-505-6520 CP 972-733-7257 Fax

CONSENT TO COMMUNICATE WITH PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN_____

PRIMARY CARE PHYSICIAN TELEPHONE NUMBER _____

PRIMARY CARE PHYSICIAN ADDRESS _____

_____

FAX _____ _____

CLIENT NAME _____

DATE OF BIRTH _____SOCIAL SECURITY NUMBER _____

DIAGNOSIS_____

AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV_____
AXIS V_____
HIGHEST GAF PAST YEAR_____

MEDICATIONS _____

_____

_____

TREATMENT _____

_____

_____

_____

_____

Your insurance company has requested that his information be sent to your primary care physician for coordination of care. These records are confidential and cannot be disclosed without your written consent, except as otherwise provided by law. You may revoke this consent at any time.

Signature _____ Date _____

Signature of legal guardian if minor_____ Date_____

[ ] Client declined to release information or stated they have no primary care physician.

Comprehensive Assessment Questionnaire – ADULT

Name:_____ **Date:** _____

What are the main problems or symptoms that caused you to seek help now? _____

Describe any stresses in your life that may have contributed to the problem: _____

Describe the history of the problem from its onset until now: _____

Have you had a similar problem in the past? __ Yes __ No If so, please describe the episodes and the dates they occurred. _____

Were you treated for this problem? __Yes __No If so, please describe the treatment you received. _____

Has this problem caused you to experience any decrease in your ability to function in the following areas? If so, please describe:

School performance: _____

Work performance: _____

Relationship with spouse/significant other: _____

Functioning as a parent: _____

Social life: _____

Ability to manage chores at home: _____

Medical History

Please list all medications you are currently taking:

Prescription Medication	Dose	Start Date (MMYY)

Please list any health problems: _____

Are you allergic to any foods, drugs or other substances? _____

Mental Health History

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Dates Seen	Reason	Medications Prescribed

Have you ever attempted suicide? __Yes __No If yes, please describe the nature of the event and the date(s) of occurrence. _____

Please list any blood relatives who have any history of mental or emotional problems (e.g. depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems, eating disorders, Attention Deficit Disorder, etc.)

Relative	Problem

Patient's Name: _____

Substance Use:
Do you use any of the following?

Substance	Yes	No	Amount	Frequency:	Daily	Weekly	Date last used
Tobacco	__	__	_____		__	__	_____
Caffeine	__	__	_____		__	__	_____
Alcohol	__	__	_____		__	__	_____
Marijuana	__	__	_____		__	__	_____
Cocaine	__	__	_____		__	__	_____
Amphetamines	__	__	_____		__	__	_____
LSD	__	__	_____		__	__	_____
Heroin	__	__	_____		__	__	_____
Pain killers	__	__	_____		__	__	_____
IV Drug Use	__	__	_____		__	__	_____

Have you ever felt that you were abusing drugs or alcohol? __ Yes __No If so, please describe when and the nature of the problem. _____

Have you tried to stop drinking? __ Yes __ No If yes, what was the outcome? _____

Have you ever attended AA? __ Past __ Current If yes, do you have a sponsor and how often do you attend meetings? _____
Have you ever attended NA? __ Past __ Current If yes, do you have a sponsor and how often do you attend meetings? _____

Family/Social History

Where were you born and raised? _____
Please list your siblings and their current ages: _____

Are you close to your siblings? _____
How would you describe your relationship with your father? _____

How would you describe your relationship with your mother? _____

Describe your childhood: _____

Were your parents divorced? __ Yes __ No If yes, how old were you? _____
With whom did you live after the divorce? _____
Did your mother remarry? __ Yes __ No Did your father remarry? __ Yes __ No
What was your relationship like with the stepparent(s)? _____

Were you ever subjected to any type of abuse (emotional, physical, sexual)? __ Yes __ No
If yes, please describe the events and ages the abuse occurred. _____

Have you lost a close family member or friend? __ Yes __ No Who? _____ When? ____

Educational History

Did you complete high school? __ Yes __ No
What kind of grades did you receive in school? _____
How did you get along with your peers? _____
How did you get along with your teachers? _____
Did you attend college? __ Yes __ No
Where? _____ Degree? _____

Patient's Name: _____

Occupational History

Are you currently working? __ Yes __ No What is your occupation? _____
What is your current position? _____
Where do you work? _____ How long have you been there? _____
Are you satisfied with your job? __Yes __ No If no, explain: _____
_____
Describe any current job stresses you may be experiencing: _____
_____
How well do you get along with your co-workers? _____
How well do you get along with your supervisors? _____
List your last two jobs and how long you worked there: _____
_____

Relationship History

Are you currently __ Single __ Married __ Divorced __ Widowed __ Living Together
How long? _____ What is your sexual orientation? _____
Describe your relationship with your spouse or significant other: _____
_____
List any stresses or problems in your relationship: _____
_____
_____
If married, what is your spouse's occupation? _____
Have you been married before (or in a long-term committed relationship)? __ Yes __ No
How many times? _____ How long did these relationships last? _____
Please describe the reason for the break-up or divorce: _____
_____
_____
If you have children, what are their names and ages? _____
_____
Describe any problems you may be experiencing with your children: _____
_____
_____
What is your religious preference? _____
How often do you attend religious services? __ Yes __ No Where? _____
Any hobbies?: _____
Is there any other important information about you that has not been covered, which you feel the therapist should know? _____
_____