THERAPY OFFICE LOCATED AT: 4545 BISSONNET, SUITE 289 BELLAIRE, TEXAS 77401

Amy M Fuller, PHD, LPC, LMFT

Today's Date: _____

CONFIDENTIAL CLIENT INFORMATION

Please complete the following 5 pages as completely as possible. Please print or write legibly.

****Each person is asked to complete pages 3 and 4 and sign pages 2 and 5.**

Client Information

Client Name: First Middle Last

Address: Street/Apt #) State Zip

Please complete the communications preferences form on page 5.

( )_____( )_____( )_____

Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_____/_____/_____ _____ _____/_____/_____

Date of Birth Age Anniversary Date (if applicable)

_____ _____

Employer Occupation/Job Title

_____/_____/_____ _____

Social Security Number Email Address

_____ _____

Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: _____

Spouse or Guardian Information

Name: First Middle Last

Address: Street State Zip

Please complete the communications preferences form on page 5.

( )_____( )_____( )_____

Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_____/_____/_____ _____ _____/_____/_____

Date of Birth Age Anniversary Date (if applicable)

_____ _____

Employer Occupation/Job Title

_____/_____/_____ _____

Social Security Number Email Address

_____ _____

Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: _____

If client is under 18, Information on Father

Father's Name: First Middle Last

Address: Street State Zip

Please CIRCLE primary phone to be used for appointment reminders.

( )_____( )_____( )_____

Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_____/_____/_____ _____ _____/_____/_____

Date of Birth Age Anniversary Date (if applicable)

_____ _____

Employer Occupation/Job Title

_____/_____/_____ _____

Social Security Number Email address

_____ _____

Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: _____

If client is under 18, Information on Mother

Mother's Name: First Middle Last

Address: Street State Zip

Please CIRCLE primary phone to be used for appointment reminders.

( )_____( )_____( )_____

Phone: Home Cell Work

It is okay to leave a message at: ☐ Home ☐ Cell ☐ Work ☐ Email

_____/_____/_____ _____ _____/_____/_____

Date of Birth Age Anniversary Date (if applicable)

_____ _____

Employer Occupation/Job Title

_____/_____/_____ _____

Social Security Number Email address

_____ _____

Highest level of Education If currently in school, Name of School

Gender: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Other: _____

Please list additional family members living in the home of the client:

Name: First	Last	Date of Birth (or age)	Relationship to client

Billing Information

Responsible Party for Payment | Relationship to Client | Phone

Address | City | State | Zip | Additional Phone

Please indicate method of payment for therapy services:
Payments are due in full at the time services are rendered. Payments will be made with ☐ Cash ☐ Check ($35 returned check fee) ☐ Credit Card on file

Please check the following regarding insurance.
☐ I do not have/or plan to use my health insurance.
☐ Please bill insurance for me. (Insurance will reimburse client)
☐ I will bill my own insurance using the receipt provided.

Insurance Information

Primary Insurance Name	Insurance Phone Number
Insurance Billing Address	City, State, Zip
Member ID #	Policy Number
Name of Insured	Social Security # of Insured
Address of Insured (if different from above)	City, State, Zip
Insured Employer:	Work Phone # of Insured
☐ Male ☐ Female Gender of Insured	Date of Birth

Secondary Insurance Name	Insurance Phone Number
Insurance Billing Address	City, State, Zip
Member ID #	Policy Number
Name of Insured	Social Security # of Insured
Address of Insured (if different from above)	City, State, Zip
Insured Employer:	Work Phone # of Insured
☐ Male ☐ Female Gender of Insured	Date of Birth

Financial Agreement (Please check each box to indicate agreement)

By seeking services, I agree to pay all fees for counseling and other services. I have received and read the document providing Information for New Clients and am fully responsible for payment of services.

- I understand that I will be charged a $85 fee for the first session not cancelled 24 hours in advance, and the full fee of $185 for all future no-shows or sessions not canceled 24 hours in advance.
- I understand sessions last 50 minutes for $185 due at the end of the session. Initial couples or family therapy sessions are 80 minutes at $275. I have received and read the document with information for new clients. I understand that I am responsible for all payments.
- If I request this office to file insurance claims, I hereby authorize this professional, staff, or designated billing entities to release any necessary information to my insurance carrier to process claims. I certify that all the information on this form is true. If client is under 18, I consent to the client's participation and accept responsibility for payment.

Client Signature | **Date** | **Parent/Guardian or Spouse Signature** | **Date**

Receipt of HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge notice of availability of Notice of Privacy Practices (see info for new clients). I understand a copy of this document can be provided at my request.

Client Signature | **Date** | **Parent/Guardian or Spouse Signature** | **Date**

CREDIT CARD (OPTIONAL)

☐ **Charge my credit card for payments on account or to pay for sessions of dependent, spouse or other.**

Credit Card Number | Expiration Date | ☐ Visa ☐ MasterCard ☐ Discover ☐ *CVC Code:

Credit Card Address | City | State | Zip | Phone Number

Signature | Date

**Please have each person present at the first session complete pages 3 and 4. *NAME:_____

FULLER LIFE FAMILY THERAPY LOCATED AT:
4545 BISSONNET, SUITE 289, BELLAIRE, TEXAS 77401

CONFIDENTIAL CLIENT INFORMATION, PAGE 3 of 5

What are your reasons for being here? _____

_____

_____

_____

How did you hear about this professional? ☐ Friend ☐ Family Member ☐ Former Client ☐ Physician ☐ Shepherd's Guide ☐ Phonebook
☐ Other Professional ☐ Pastor ☐ Website: (website name:_____)
☐ Other: _____ Please list name or more information:_____

Medical and Emergency Information

_____ _____ _____
Name of Primary Physician | Doctor's Phone Number | Date of last Visit

_____ _____ _____
Contact in Case of Emergency: Name Address | Phone Numbers | Relationship to client

Please list all current medications:

Name of Medication	Dosage	Times per day (am/pm)	Prescribing Physician	Type of medication

Current Client Symptoms: Please rate all that apply from 1 to 3 (1-Low, 2-Moderate, 3-High Concern)

☐ Family problems	☐ Feel sad or depressed	☐ Anxiety/worry	☐ Hear strange things
☐ Marital/relationship issues	☐ Cry often	☐ Stress	☐ See strange things
☐ Trouble communicating	☐ Feel hopeless	☐ Extreme fear	☐ Wanting to hurt others
☐ Physical or sexual abuse	☐ Anger problems	☐ Panic attacks	☐ Suicidal thoughts
☐ Domestic violence	☐ Frustration	☐ Aggressive behaviors	☐ Others are out to get me
☐ Sexual problems	☐ Trouble concentrating	☐ Nightmares	☐ Thoughts of Death
☐ Intimacy issues	☐ Trouble sleeping	☐ Upset stomach	☐ Wanting to hurt myself
☐ Divorce	☐ Feel guilty	☐ Health Problems	☐ Legal problems
☐ Pre-marital counseling	☐ Low self-esteem	☐ Severe pain	☐ Financial problems
☐ Grieving	☐ Loss of appetite	☐ Headaches	☐ Smoke cigarettes
☐ Lack of sex drive	☐ Dramatic weight changes	☐ Sweating	☐ Alcohol use
☐ Spiritual Issues	☐ Feel tired or low energy	☐ Trouble breathing	☐ Drug use
☐ Can't make friends	☐ Lack of motivation	☐ Quick mood changes	☐ Restless/Can't sit still
☐ Feel Lonely	☐ Problems at work	☐ Can't stop thinking	☐ Impulsive
☐ Withdrawn from others	☐ Problems at school	☐ Eating Disorder	☐ Other:_____

Please explain any of the above symptoms: _____

_____

_____

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Religion (This section is optional)

_____ Please describe your involvement: ☐ Active ☐ Somewhat Active ☐ Inactive
Religious Affiliation If Active or Inactive, How long? _____

What are your religious beliefs? _____

****Each person present at the first session is asked to complete this page.** ***NAME:_____**

Client History	**(Circle YES or NO. If YES, please Explain Below)**		
Any **previous counseling**? If so, with whom? When and for how long?	NO	YES	
Any major illnesses or serious **medical problems**?	NO	YES	
Any **Previous hospitalizations**?	NO	YES	
Does client have **addictions**? (Drug, alcohol, pornography, gambling, computer, etc).	NO	YES	
Does client **smoke**? If so, how much per day?	NO	YES	
Does client drink **alcoholic** beverages? If so, how much per day?	NO	YES	
Has client had recent **changes in weight** or eating habits? Any history of **eating disorders?** (anorexia, bulimia, overeating, emotional eating)	NO	YES	
Has client been in **trouble with the law**?	NO	YES	
Has client had a history of employment changes or **difficulty at work?**	NO	YES	
Has client had **trouble with school**? (truant, etc.)	NO	YES	
Has client exhibited **physical aggression or threats** of harm toward others?	NO	YES	
Has client exhibited **cruelty to animals**?	NO	YES	
Has client shown **destructive tendencies toward property?** (setting fires, vandalism or destruction of property)	NO	YES	
Does client have **military history**? (If yes, list military history and discharge type. Any field duty conducive to trauma or post traumatic stress?)	NO	YES	
List all **major traumas.** (loss of child or loved one, robbery, feared death experiences)	NO	YES	
Does client have a history of **sexual, physical or emotional abuse?**	NO	YES	
Has client exhibited **inappropriate sexual behaviors**?	NO	YES	
Did client experience any known **developmental problems** in infancy, childhood, or adolescence? (hearing, speech, walking, surgery, premature birth, learning disabilities, etc.)	NO	YES	
Has client had any **legal issues**, past and or present?	NO	YES	
Any other situation, experience or concerns which therapist should be aware?	NO	YES	

Communication Preferences Form

Amy Fuller PhD
Help for today, Hope for Tomorrow

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

Name of Client	Name of Spouse/Guardian
Primary Email	Primary Email (Spouse/Guardian)
Primary Phone	Primary Phone (Spouse/Guardian)

It may become useful during the course of treatment to communicate by email, text message or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Dr. Fuller there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. For this reason, Dr. Fuller uses only HIPPA Compliant Secure forms of communication UNLESS you indicate a desire to communicate in non-secure means. Dr. Fuller offers encrypted email and a secure texting platform to ensure HIPPA-Compliance. (*See Info for New Clients and Communication Policies for more info.)*

Client	Spouse	
❍	❍	**EMAIL:** I consent to communicate with Dr. Amy Fuller through unsecured / unencrypted email.
❍	❍	I prefer all communication with Dr. Fuller via encrypted secure email.
❍	❍	I consent to any scheduling related communication via unencrypted/unsecured email, but I prefer any financial or clinical information come through encrypted email.
Client	Spouse Guardian	**TEXT MESSAGES:** Dr. Fuller uses a HIPPA-Complaint service called 8X8 to send secure text messages. All text messages are related ONLY to scheduling. Dr. Fuller's direct 8X8 number: (713) 893-3669
❍	❍	I consent to receive/send scheduling related text messages at the above number.
❍	❍	I prefer not to send or receive scheduling related text messages with Dr. Fuller.
Client	Spouse	**RESOURCES (OPTIONAL):** Dr. Fuller and Fuller Life Family Therapy share resources and articles related to mental, relational, emotional and spiritual well-being on a monthly newsletter.
❍	❍	Yes I would like to receive email from Amy Fuller PHD and Fuller Life Family Therapy.

APPOINTMENT REMINDERS: Appointment Reminders are a courtesy offered by phone call and email approximately 36 hours prior to the appointment. ***Only one phone number and email address can receive the reminders.***

EMAIL REMINDERS: Select only one please *(these are NOT encrypted emails)*

- ☐ Please send email reminders to the above client email address above.
- ☐ Please send email reminders to the spouse/guardian email address above.
- ☐ I/we do not wish to receive email reminders.

PHONE REMINDERS: Select only one please

- ☐ Please use above client primary phone for appointment reminders.
- ☐ Please us the above spouse/guardian phone for appointment reminders

SOCIAL MEDIA:

Dr. Fuller is active on various social media platforms providing professional resources for mental and relational health. You are welcome to follow Dr. Fuller on her blog, the Fuller Life blog, Twitter, Facebook, Connect on Linked In or Scoop It! If you choose to do so please know this may compromise your confidentiality at your own choice. Please do not send any direct communication through these professional social media accounts since they are not confidential. Furthermore, in order to ensure your confidentiality, please know that Dr. Fuller will not directly request to connect with you on these platforms. (*See Information for new clients Social Media Policies for more info.)*

PHYSIOLOGICAL MONITORING and VIDEO RECORDING:

Dr. Fuller regularly consults with other experts in the field to improve the quality of her clinical skills. Dr. Fuller may video record a session to use for consultation or training to ensure quality care or enhance the training of therapists with Fuller Life Family Therapy Institute, a post-graduate training site for master's level counselors and therapists. All recordings and information from physiological monitoring are used solely for the purpose of training and improved clinical care. Signature below grants permission to record therapy sessions and use physiological monitoring during session for training purposes and enhance clinical care. If you have questions, please discuss them with Dr. Fuller or her assistant.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time. I understand I can find out more about Dr. Fuller's Communication Policies and Social Media Policies in the Information for New Clients Document and I will comply with the guidelines provided in these policies.

Signature of client	Date	Signature of Spouse/Guardian	Date

Signature of Therapist: _____ Date: _____

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Any other situation, experience or concerns which therapist should be aware?	NO	YES	