

Kristina Fernandez, M.A., L.P.C.-supervisor
9950 Cypresswood, #300
Houston, TX 77070
281-955-0050 office 281-955-0199 fax

Professional Profile and Overview of Therapy: I am a licensed professional counselor with a master's degree in counseling psychology from Our Lady of the Lake University. As a psychotherapist, I do not prescribe medication, but I am trained in a broad range of therapeutic techniques. Please know that while it is impossible to guarantee any specific results regarding your therapeutic goals, I will work with you as diligently as possible to achieve the best possible results for you.

About Therapy: Your first appointment will consist of obtaining detailed information about your problems. Following this, I will give you my treatment recommendations and we will develop a plan. In general, therapy sessions are usually weekly or every other week. The length of treatment varies widely depending on the issues we need to work through, but I will discuss this with you. If you are using your insurance, your session will be 45 minutes long. Insurance companies have made an industry wide decision to limit our sessions to 45 minutes.

Emergencies: If an emergency arises after hours (generally office hours are 9-5 pm, Monday through Friday) your call will be forwarded to my cell phone. I try to respond immediately, but if there is a true medical emergency, please call 911 or go to your nearest hospital emergency room.

Payment: Payment in full, or if you are using your insurance, payment of your co-pay in full is due at the time of services. The fee for any returned check is \$25. **As a courtesy, I will file the insurance claim on your behalf, however, if there is an issue with your insurance, it is your responsibility to resolve it, as the charges for services belong to you. My relationship is with you, not your insurance company. I reserve the right to refuse service for non-payment.**

Cancellation Policy: If you need to cancel an appointment, it must be cancelled at least 24 hours in advance of the appointed time, or you will need to pay for the session in full. Your insurance company will not pay for missed appointments. Payment must be received before further sessions will be scheduled.

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Clients rights/informed consent

I understand I have chosen to undergo therapy and that this choice is voluntary and that I may terminate at any time. I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist to resolve my difficulties. I understand that during the course of treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my issues.

I understand that records and information collected about me will be held or released in accordance with the state law regarding confidentiality of such records and information. I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others and in cases of child or elder abuse. I understand that there may be circumstances in which the law requires my therapist to disclose confidential information (e.g., in the case of a subpoena).

I understand that my insurance company will not pay a claim without a diagnosis code, and they may contact my therapist regarding my care and outcome.

I understand that my therapist, my insurance company representative, and my primary care physician may exchange any and all information pertaining to my therapy, to the extent that such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review. I understand, 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 and that if I do not revoke my consent, it will expire automatically one year after all claims for treatment have been paid for.

Signature of client

Date

Signature of parent or guardian

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Assignment of Insurance Benefits

Date: _____ / _____ / _____

Patient: _____

Employer: _____

Group No.: _____

SS#/ID#: _____

I hereby instruct _____ insurance company to pay by check payable to:

Kristina Fernandez, M.A., L.P.C.-S

For the professional or medical expense benefits allowable. This a direct assignment of my rights and benefits under this policy.

I hereby authorize release of medical information necessary to file a claim with my insurance carrier. A copy of this signature is as valid as the original.

I understand that I am responsible for any balance not covered by me insurance carrier.

Signature of policy holder

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Patient Information

Patient Name: _____
Last First

Single Married Divorced

Sex M / F Birthday ___ / ___ / ___ **Age** ___ **SS#:** _____

Home address _____

City State Zip

Cell phone () _____ - _____ **Business phone ()** _____ - _____

Employer: _____

email: _____

Insured's Information

Relationship of insured to patient: Self Parent Child Spouse Other

Authorization Number: _____ No. of sessions authorized: _____

Insured's name: _____ **DOB:** _____

Insured's SS# _____

Address if different from client

Insured's Employer _____ **Insured's Phone** _____
Work

ID# _____ **Group#** _____

Insurance company Name: _____

Insurance Company Address: _____

Insurance Company Phone () _____ - _____

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Adult Psychosocial History

Who lives in your home _____

Occupational Background: _____ **How Long:** _____

Previous occupation: _____ **How Long:** _____

Educational Background

Check your level of education: _____ Did not complete 12th grade
_____ GED
_____ High school diploma
_____ Attended college
_____ Associates degree
_____ Bachelors degree- Major _____

Childhood History

I was raised by _____

Relationship with primary caretakers _____

Relationship with mom _____

Relationship with dad _____

Relationship with grandparents _____

Birth order Oldest to youngest _____

Relationship with siblings _____

Sexual preference: Heterosexual _____ Homosexual _____ Bisexual _____

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Current Marital Status:

Current spouses name: _____ Years marriage _____

How many times married? _____

How did you meet your spouse? _____

What attracted you to your spouse? _____

How long did date prior to marriage? _____

What are the biggest problems you face in life currently (biggest to smallest)

1. _____

2. _____

3. _____

4. _____

5. _____

Children Yes _____ No _____

Name and age _____

Name and age _____

Name and age _____

Drug and alcohol history

How much do you drink? _____ amount? _____

type? _____

frequency? _____

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What drugs do you currently take? _____

frequency _____

Do you feel you have a problem with drugs or alcohol? _____

Have you ever participated in a 12 step program? _____

when? _____ where? _____

how long? _____

Psychiatric history

Have you ever attempted suicide? _____ If so, at what age? _____

Have you ever sought out patient treatment? _____

When? _____ With whom? _____

How long did you participate? _____

Psychiatrist name _____

Address _____

Phone _____

Psychiatric medications _____

For how long? _____

Inpatient history? _____

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Abuse history

Have you been physically abused?_____

By whom?_____

Have you been sexually abused?_____

By whom?_____

Have you been emotionally abused?_____

By Whom?_____

Describe any other emotionally disturbing experiences you have had

Describe any stressors you have had in the past year (i.e. pressures, conflicts changes, loss)._____

Therapy goals

Describe the main problem that troubles you the most?_____

How long has the problem has existed?_____

Why are you seeking help at this point?_____

Additional problems you think need explorations?_____
