SUSIE ROBINSON, LCSW
Licensed Clinical Social Worker

REGISTRATION FORM
CHILDREN

NAME:_____

Date of Birth:_____ Social Security Number_____

Parent(s)/Guardian(s):

Name: _____Phone _____

Name:_____Phone_____

ADDRESS:_____

CITY/STATE/ZIP_____

Emergency Contact Name & Number:_____

Email_____
*Please note: Email correspondence is not considered to be a confidential medium of communication

How were you referred?: _____

INSURANCE INFORMATION: Please provide a copy of your insurance card OR

Insurance company name:_____

ID # _____GROUP #_____

Name of Policy Holder _____

Birthdate of Policy Holder_____

Employer _____

SIGNATURE CONSENT TO BILL INSURANCE_____

Your signature allows me to bill your insurance, but you remain responsible for charges if your insurance refuses payment. Your payment in the form of credit card, cash or check, is due at the time of service. I also accept Pay Pal through my website at www.somocountytherapy.com

431 Nursery Rd, Suite B-700
The Woodlands, TX 77380
srfamconnect@gmail.com (281) 658-7988

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Health and Social Information

What is the nature of the problem that brings you to therapy? _____

_____

Does your child believe they have a problem? _____

Child's School and Grade: _____

Does he/she like school?_____Academic issues?_____

Is this child currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ____Yes _____No

Is this child currently taking psychotropic medications (antidepressant, ADD, anti-anxiety, etc.)?

___Yes ____No If yes, please list: _____

How is his/her current physical health? Poor Satisfactory Excellent

Please list any specific health concerns:_____

Is he/she having any problems sleeping or eating? _____Yes ____No

Please describe: _____

Does your child have good friends? _____Yes ____No

Please describe any social concerns: _____

In the last year or so, have they experienced any significant life changes or stressors, such as deaths, major illness, moves? Please list.

_____

_____

Is your family religious or spiritual? If so, what is your faith or spiritual perspective?

_____

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What do you like most about your child?

_____

What goals do you have for therapy?

_____

Additional information you would like for me to know:

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CONSENT FORM

Psychotherapy is a safe and effective way to address a variety of personal, emotional, and relationship problems. It is completely voluntary on your part, and you are expected to be an integral part in planning and carrying out your treatment plan. There is no minimum number of sessions required, and you may stop therapy at any time without penalty.

You have the right to confidentiality. I may not discuss your particular case without your written permission, except in certain circumstances. These include, but are not limited, to the following:
I am required by law to report child abuse, or the abuse of an elderly or disabled person.
I may consult your treating physician without prior notice in the event of an emergency.
If you are suicidal I will contact a family member or your treating physician.
If you are threatening to harm someone else and I believe it is a credible threat, I am required to contact law enforcement.
If I, or my records are subpoenaed I am required by law to comply.
If you are using your medical insurance to pay for sessions, I am required to give your name, ID number, ***(which may be your social security number)*** a diagnosis, the date(s) of service, and what type of service was provided. I cannot be responsible for the confidentiality of information once I have sent it to the insurance company.

You have the right to review your client records. In the event that you wish to review your records, please make a written request to me at the address below. I must comply within 30 days or give reason for my denial. I am allowed to charge reasonable fees for the records request.

Limitations of services: I cannot prescribe medication, I do not have hospital admitting privileges, nor do I have any specialized treatment program. Many people need a higher level of care than I can provide, and I will be happy to work with you to find the appropriate level of care, while still providing you with therapy.

Please give 24 hour notice if you need to change or cancel your appointment. I am very understanding about emergencies, however, if you miss an appointment without adequate notice, I may charge you for the missed appointment. Two missed appointments will result in termination of services.

My fee for service is $95.00 per session. Your part of that fee is:_____

Client Signature_____

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