

Woodlands Family Institute, P.C.

Carla J. Wynn MSW, LCSW
Psychotherapist

PERSONAL DATA RECORD

Client Name _____ Date of Birth _____

Address _____

City/State/Zip _____

SSN _____ TXDL _____

Employer/School/Address _____

May we leave a message at any of the following?

Home phone (circle one) _____ Yes No

Work phone (circle one) _____ Yes No

Cell phone (circle one) _____ Yes No

Unencrypted email address _____ Yes No

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other _____

Referred to our office by _____

May we send a **thank you** to the person who referred you? (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

Credit Card Payment Authorization for Auto Charge

Name _____ Relationship _____

Address _____

Phone _____

MC/VISA No. _____ Exp. Date _____

Name as listed on Card _____

Signature of Authorized User _____

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Financial Responsibility

Name of person(s) financially responsible for this account _____

Address/phone if different from client _____

Signature(s) _____

Relationship to client _____

Emergency Contact

Name _____ Phone _____

Alternate phone _____ Address _____

Relationship to client _____

You may change the above instructions at any time by requesting another form or otherwise instructing in writing.

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ACKNOWLEDGEMENT

I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies**. I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

Client or Authorized Representative Signature

Date

Refuse to Sign _____

Unable to Sign (specify reason) _____

Signature of Person Documenting Refusal or Inability to Sign

Date

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CONSENT FOR TREATMENT

Client Name _____ Date of Birth _____

I give full consent for myself, my child/adolescent or dependent due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

Authorized Signature

Date

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Client Information Statement

The Texas Boards of Examiners of Social Workers and Marriage and Family Therapists were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of social work and family therapy. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

After reading the agreements, please ask about any part of the agreement that you do not understand.

Information, Consent and Policies

We are honored that you have selected the Woodlands Family Institute to provide counseling or psychological services. All of us wish to do our best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I am a licensed psychotherapist who has practiced in The Woodlands since 1998. I am accredited by the state of Texas as a Licensed Masters Social Worker, Licensed Clinical Social Worker/Psychotherapist. I received a BSW from the University of Kansas and Texas Southern University, and an MSW from the University of Houston. My experiences include child, adolescent, adult, family psychotherapy; creation and implementation of intensive outpatient interventions addressing the individual, family and subsequent interactions with the environment, workshop presentations regarding dual diagnosis, bipolar disorder, anger management, chronic illness and reactive attachment disorder. Most recently, my research in the area of Pediatric Bipolarity and self-regulation was published in the Journal of Brief Therapy (2002).

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I hold an abiding belief that no matter how difficult a person's circumstances may be it is possible to produce meaningful change. I view the therapeutic relationship as collaboration with my client on a unique journey towards self-enhancement, wellness and goal attainment. My theoretical basis takes into consideration the developmental stage of not only the individual but the family as well. In this effort, we explore the emotional and psychological demands of individuation, interpersonal and adaptive coping skill development. As a client you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you can feel self-assured to carry on without my intervention.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be safe and secure as possible so that we concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at anytime you are dissatisfied with my services, please let me know.

Children can be joyful and energetic, but with respect to the concerns which brought you to us, we request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results.

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Office Policies

1. **Fees Schedule:** All fees for services or co-pay amounts are due at the time of the appointment. For payment, please see the office staff prior to each appointment. Follow-up appointments will not be honored if your account is overdue. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a \$10.00 rebilling fee for every statement sent out after the first billing. There is also a \$25.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and will impact your credit rating.

Session fee: \$150.00 (50 minute duration)

After hour's session fee: \$225.00

Miscellaneous: Charges for other professional services are prorated on the basis of \$150.00 per hour, 15 minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is prorated at the rate of \$150.00 per hour, "portal to portal", that is, for the time I am out of the office on your behalf.

Legal testimony: Please be advised that I do not provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be so ordered, fees will be charged at the rate of \$500.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. All fees of this nature are **payable in advance.**

2. **Office hours:** Monday through Thursday, 9:00am-7:00pm. Friday, the office staff is available 8:00am-4:00pm. Any hours beyond stated office hours (Mon-Thurs.) are considered as "after hours" and will be charged accordingly. After hours time is generally reserved for family time and self-care.
3. **Cancellations:** The scheduling of an appointment involves the reservation of time specifically for you. Therefore, 24 hours cancellation notice is required so that there will be no charge to your account. If you are unable to meet this time schedule, but we are able to assign your appointment time to another client, you will not be charged. Due to the fact that your appointment is contracted time specifically set-aside for you, cancellations in advance will be appreciated. *Please note that insurance companies do not reimburse for missed appointments.*

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4. **Insurance:** Your health insurance policy is a contract between you and your insurance company. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. Some insurance companies reimburse clients for services and some do not. Those that do usually require a standard amount be paid by you before reimbursement is allowed, and then usually a percentage of the fee is reimbursable. The client remains responsible for payment in full, including any portion not reimbursed by insurance. Please be aware that third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated.

The office staff is happy to provide you with insurance ready receipts for filing your claim. WFI does not file out-of-network insurance claims.

5. **Confidentiality:** All information disclosed within sessions is confidential and may be revealed only in certain situations. At times I may legally and/or ethically be required to share information about you without your consent. Such situations are, but are not limited to the following:

- Information released to other professionals involved in your treatment.
- If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties.
- If you are determined to be in imminent danger of harming yourself or someone else unless protective measures are taken.
- If you disclose abuse or neglect of children, the elderly, or disabled person.
- In the instance of reasonable suspicion of child or elder abuse.
- If you disclose sexual misconduct by a therapist.
- To individuals, corporations or governmental agencies involved in paying or collecting fees for services (this includes insurance companies). *Please be advised that insurance reimbursement usually requires background information, including substance abuse, diagnostic criteria and treatment plan form completion. In addition, please note that most applications for health insurance include a release of information for medical records (this would include therapy/counseling records).*

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- In criminal court proceedings.
 - In legal or regulatory actions against a professional.
 - In proceedings in which a claim is made about one's physical, emotional or mental condition.
 - When disclosure is relevant in any suit affecting the parent-child relationship. This includes divorce and child custody deliberations.
 - Where otherwise legally required.
6. **Emergency services:** It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for clients' day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message with the answering service, making sure to state that your call is an emergency. We will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. We can be reached at 281-363-4220 or 713-866-4494. If we are unable to respond quickly enough, please call 911 or your local emergency room.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

Signature

Date

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PSYCHOSOCIAL HISTORY

Date _____

Name of Patient _____

Date of birth _____

Presenting Problems:

- Recent life transition
- Depression, isolation, withdrawal
- Suicide gesture, attempt or ideation
- Homicidal ideation
- Self-abusive behavior
- Abuse (physical, emotional, sexual)
- History of traumatic life events (in addition to the previous)
- Neglect, abandonment
- Marginal to low IQ
- Difficulty at school or work
- Difficulty with authority
- Commits unlawful acts
- Under socialized (difficulty making friends)
- Anger outbursts/rage
- Runaway from home or placement
- Impulse control problems
- Low self-esteem
- Physically aggressive
- Destruction of property
- Sexual dysfunction
- Does not feel guilty about wrongdoing
- Paranoid thoughts, delusions
- Hallucinations (auditory, visual, tactile)
- Gender identity problems
- Excessive worry, racing thoughts, obsessions
- Compulsive behavior
- Substance abuse

Have you had any **treatment** for these problems before today? Y N

If yes, when? Where? Who was your doctor or therapist?

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History of psychiatric hospitalizations

Date _____ Location _____ Outcome _____

Date _____ Location _____ Outcome _____

Date _____ Location _____ Outcome _____

Family past psychiatric history

Family medical history

Personal past medical history

Drug and Alcohol Abuse

Any **family** history of drug and/or alcohol usage? Please list and describe _____

Any **personal** history of drug/alcohol usage? List and describe _____

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Family History (include spouse, significant other, children, parents, step families, adoption history, etc.)

Name	Relationship	Age	Living where?

Marital status of patient

Married _____ How long _____

Divorced _____ How long ago _____

Separated _____ How long ago _____

Widow/widower _____ How long ago _____

Other _____

Other significant adults or children in patient's life (Please include type of relationship-e.g. supportive, conflictual, etc.)

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Traumatizing Life Events

Have you experienced any history of significant abuse (physical, emotional or sexual)?

Please briefly describe _____

Any history of **significant life events** such as deaths, separation from parent(s), frequent moves, terminal illnesses in the family or close friendship?

Relationship issues

Are you currently dating? _____ at what age was your first date? _____

Are you sexually active? _____ at what age was your first sexual encounter? _____

Would you consider yourself to be heterosexual / homosexual / bi-sexual _____

Would you describe yourself as timid or as social (easily makes friends and participates in social functions)

Cultural Influences

With what ethnic/cultural groups do you personally identify? _____

With what ethnic/cultural group does your family most identify? _____

Describe any cultural values or beliefs that may impact treatment _____

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Educational History

Highest degree earned _____

Current School attending _____ Grade _____

Average grade performance _____

Overall motivation to attend school _____

Extracurricular activities _____

Employment History

Present employment status-where-how long? _____

Positive/negative aspects of current position _____

If on leave of absence or disability, will you return to present job? _____

Special interests/hobbies/skills

Desired Treatment Goal (s)

Additional Comments _____

Signature

Date