**DAVID B. JONES, PH.D., L.P.C.**

**Licensed Professional Counselor**

Name:_____ Today's Date:_____

Address:_____ Social Security #:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Office Phone:_____ E-Mail:_____

Age:_____ Date of Birth:_____ Marital Status:_____

Occupation:_____

Place of Employment:_____

Education:_____

Briefly describe your reason for seeking help:_____

_____

Who were you referred by:_____

Who is your primary care physician:_____

List any physical conditions for which you currently receive treatment:

_____

List any medications you are taking:_____

Have you ever received psychiatric or psychological help of any kind?_____

If you have, please explain:_____

_____

List the members of your family and all others in your home:

Name(s) Age/Birth Date Relationship Occupation

_____

_____

_____

_____

_____

_____

Please add any additional information that you feel may be useful:

_____

_____

_____

I understand that I am financially responsible for all charges for professional services provided to me. I understand that payment of services rendered becomes due and payable at the time of service. I further understand that, in the event my account is in default, collection or legal proceedings will be instituted against me, and I agree to pay all costs for such proceedings. In the event the account is turned over to a collection agency, I will be responsible for the agency's fee. I attest to the fact that I have read the above and fully understand its meaning.

_____ _____

Responsible Party's Signature Date

## Insurance Authorization and Assignment

I hereby authorize David B. Jones, Ph.D., L.P.C. to furnish information to insurance carriers concerning my treatment, and I hereby assign to Dr. Jones payments rendered to myself or my dependents.

_____ _____

Responsible Party's Signature Date

## CLIENT RIGHTS AND RESPONSIBILITIES

To be an effective consumer of counseling services, it is important that you know about your rights and responsibilities and about our obligations to you. Please read this statement carefully and discuss any questions you might have with us.

## OUR COMMITMENT TO YOU

We are dedicated to providing quality counseling, testing, and consulting services. We believe that each client should receive competent, prompt, and respectful services regardless of race, sex, creed, or national origin. When necessary, we consult with other specialists, and may refer you to additional resources.

## YOUR RIGHTS

When you become a client, you have the right to:

1. Confidentiality. It is our policy to respect you privacy and to protect the confidentiality of your relationship with us. It is also our policy to inform you of the limits we have in protecting this right to confidential care. Some limitations are imposed by state statute and others come from the ethical standards for therapists or counselors. They are:
    a. Ethical standards encourage therapists to confer with other professionals when helpful and appropriate provided you have signed a written release of information form.

b. We are obligated by law to inform relevant parties when there is a clear and imminent danger to an individual to society. We also must report to appropriate authorities when there is evidence of child abuse or abuse of a vulnerable individual.
c. By law, we must comply when records are subpoenaed by proper legal authority.

2. Cost of Services Information. You have the right to be informed of the cost of professional services before receiving the services.

**YOUR RESPONSIBILITIES**

1. You are responsible for supplying accurate and complete information about yourself, your past illnesses, previous counseling, medications, and family/work history, when appropriate.
2. You are responsible for keeping appointments. To avoid charges, **CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE**, by calling (601) 346-4479.
3. You are responsible for honoring your financial agreement.

I have read the information on client's rights and responsibilities and understand and accept these policies.

_____ _____

**Signature** **Witness**

_____

**Date**