Dr. Kimberly Joiner King

Personal Information

Patient's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____

Male ____ Female ____ Minor ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Address: _____

City, State, Zip: _____ Referred by: _____

Employer: _____ Occupation: _____

Referred by: Yellow Pages; Insurance Company; Other: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Where would you like us to leave reminder messages: Home ____; Work ____; Cell Phone ____; Email ____; None ____

If there is emergency at the office and we must cancel the appointment, where should we call: _____

In the event of an emergency with you, whom should we contact: Name: _____

Relationship: _____ Work # _____ Home # _____

Who is responsible for this account/ Who is the Insured?

Name: _____ Relationship to Patient: _____

Birthdate: _____ Soc. Sec. # _____

Address: _____

City, State, Zip: _____

Employer: _____

Occupation: _____ Work # _____ Home # _____

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or to my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the provider of care insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I give Dr. Kimberly Joiner King the right to seek the services of a bill-collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid to him for services rendered and/or for cancelled or missed appointments.

_____ _____

Signature of patient or parent if minor Date

Dr. Kimberly Joiner King

About Your Education:

Where did you attend public school? _____

Did you attend college? When, where? _____

Any plans to further your education? _____ If so, when and what? _____

About Your Relationships:

Please list your marriage(s) or other important significant other relationships

	Spouse's name	Year Begun	Year Ended	Married to this person	Children from this relationship & ages
1					
2					
3					
Please list all people who live with you:					

About Your Family:

Relative	Name	Living?	Current age, or age at death	Deceased? Yes or No	Occupation
Father					
Mother					
Brother(s)					
Sister (s)					
Any other significant person?					

About Your Health:

Who is your Doctor? _____ Last Visit: _____

Concerns? _____

Do you have any chronic medical concerns? _____. If so, please list: _____

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/ seizures, and any other medical conditions you have had: _____

List all medications or drugs (legal or illegal) you take or have taken in the last year. _____

_____

Dr. Kimberly Joiner King

About Your Concerns

Please mark all of the items below that currently apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ❑ Abuse-emotional
- ❑ Abuse-neglect
- ❑ Abuse-physical
- ❑ Abuse-sexual
- ❑ Aggression
- ❑ Anger
- ❑ Anxiety
- ❑ Arguing
- ❑ Attention Problems
- ❑ Career concerns
- ❑ Childhood issues (your own childhood)
- ❑ Children-care
- ❑ Children-custody
- ❑ Children-management
- ❑ Choices I have made
- ❑ Codependence
- ❑ Compulsions
- ❑ Compulsive spending
- ❑ Concentration Problems
- ❑ Confusion
- ❑ Crying
- ❑ Deaths
- ❑ Debt
- ❑ Decision making
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression
- ❑ Distractibility
- ❑ Divorce
- ❑ Drug Abuse-over-the-counter medications
- ❑ Drug Abuse-prescription medications
- ❑ Drug Abuse-street drugs
- ❑ Drug Abuse-Alcohol
- ❑ Eating-poor appetite
- ❑ Eating-making myself vomit
- ❑ Eating-overeating
- ❑ Eating-under-eating
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue
- ❑ Fears
- ❑ Financial troubles
- ❑ Friendship problems
- ❑ Gambling
- ❑ Goals not being met
- ❑ Grieving
- ❑ Guilt
- ❑ Headaches, pains
- ❑ Health
- ❑ Hostility
- ❑ Impulsive spending
- ❑ Impulsiveness
- ❑ Indecision
- ❑ Inferiority feelings
- ❑ Inhibitions
- ❑ Interpersonal conflicts
- ❑ Irresponsibility
- ❑ Irritability
- ❑ Judgment problems
- ❑ Laziness
- ❑ Legal matters
- ❑ Loneliness
- ❑ Loss of control
- ❑ Losses
- ❑ Low energy
- ❑ Low frustration tolerance
- ❑ Low income
- ❑ Low mood
- ❑ Marital coldness
- ❑ Marital conflict
- ❑ Marital distance
- ❑ Marital infidelity/affairs
- ❑ Medical concerns
- ❑ Memory problems
- ❑ Menopause
- ❑ Menstrual problems
- ❑ Mixed feelings
- ❑ Mood swings
- ❑ Motivation
- ❑ Mourning
- ❑ Obsessions
- ❑ Outbursts
- ❑ Oversensitive to criticism
- ❑ Over-sensitive to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Phobias
- ❑ Physical problems
- ❑ PMS
- ❑ Poor self-care
- ❑ Procrastination
- ❑ Relationship problems
- ❑ Relaxation
- ❑ Re-marriage
- ❑ Risk taking
- ❑ Sadness
- ❑ School problems
- ❑ Self Abuse-burning
- ❑ Self Abuse-cutting
- ❑ Self Abuse-other
- ❑ Self Abuse-scratching
- ❑ Self-centeredness
- ❑ Self-control
- ❑ Self-esteem
- ❑ Self-neglect
- ❑ Separation
- ❑ Sexual conflicts
- ❑ Sexual desire differences
- ❑ Sexual dysfunctions
- ❑ Sexual-(other issues)
- ❑ Shyness
- ❑ Sleep-insomnia
- ❑ Sleep-nightmares
- ❑ Sleep-too little
- ❑ Sleep-too much
- ❑ Step parenting
- ❑ Stress
- ❑ Stress management
- ❑ Suicidal thoughts
- ❑ Suspiciousness
- ❑ Temper problems
- ❑ Tension/Stress
- ❑ Thought disorganization
- ❑ Threats of violence
- ❑ Tiredness
- ❑ Tobacco use
- ❑ Violence
- ❑ Work Problems
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Employment problems
- ❑ Employment-lack of
- ❑ Employment- overdoing
- ❑ Employment- Terminations
- ❑ Other Concerns: _____

_____

_____

_____

_____

_____

Dr. Kimberly Joiner King

About Kimberly King, Ph.D., LPC-S, RPT-S

Please Read and Initial Each Statement:

____ I understand that Kimberly King is a Licensed Professional Counselor in the state of Texas and a Registered Play Therapist and Supervisor and holds a Ph.D. from the University of North Texas.

____ I understand that Kimberly King works with children, adolescents, and adults in individual, group, and family counseling.

____ I understand that as my therapist, or the therapist working with my child, I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

____ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.

____ I understand that if I am concerned about slow progress or lack of progress I have the right to speak to Kimberly King about this.

____ I understand that Kimberly King can perform some testing and will refer out for testing she is not authorized to give in the state of Tennessee.

____ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.

____ I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Kimberly King to tell someone else in writing or verbally, b) Kimberly King determines that her client poses a threat to them self or others, c) she is ordered by a court to disclose information, or d) She suspects that child abuse has taken place, at which time she

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____ I understand that counseling can improve as well as upset the equilibrium in any person or family.

____ I understand that if I have a complaint I cannot resolve with Kimberly King and I wish to file a formal complaint I may contact the Texas State Board of Examiners of Licensed Professional Counselors at at (512) 834-6658.

____ I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to Kimberly King.

____ I understand there is a returned check fee of $25.

____ I understand that all co-pays are due at the time of service.

____ I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of $60.00 which will be debited from my Visa or MasterCard.

____ I understand that the rate for an initial session is $130.00 and subsequent sessions are $130.00. These fees are for a play therapy session of 45 minutes and an individual session of 50 minutes.

____ I understand that Kimberly King is not a psychiatrist, she is a Doctorate level therapist, and as such cannot recommend or prescribe medications but can encourage clients to see an M.D. for a medication evaluation.

____ I understand that should I have Dr. Kimberly King subpoenaed to attend court regarding myself or my child that I will need to provide a $1000 retainer for her services.

____ I understand that her time for attending court includes preparation of files for court, drive time to and from court, and time in court. The hourly rate for attending court will be $175.00 per hour.

By signing below I confirm that I have read, agree to and received the above information:

_____ _____

Client/Parent of Client Date Received and Read

This copy is for you to read, sign, and leave with Kimberly King

Dr. Kimberly Joiner King

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This copy is for you to read, sign, and keep for your records

Dr. Kimberly Joiner King

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d) – Effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL:

Last _____ First _____ Middle _____

OTHER NAMES USED: _____

DATE OF BIRTH: Month _____ Day _____ Year _____

ADDRESS: _____

_____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **ALT. PHONE:** _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dr. Kimberly Joiner King

REASON FOR DISCLOSURE (Choose only one option below):

____ Treatment/Continuing Medical Care
____ Billing or Claims
____ Legal Purposes
____ School
____ Other _____
____ Personal Use
____ Insurance
____ Disability Determination
____ Employment

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

____ All health information
____ Physician's Orders
____ Progress Notes
____ Pathology Reports
____ Lab Results
____ Other _____
____ History/Physical Exam
____ Patient Allergies
____ Discharge Summary
____ Billing Information
____ Consultation Reports
____ Past/Present Medications
____ Operation Reports
____ Diagnostic Test Reports
____ Radiology Reports & Images
____ EKG/Cardiology Reports

Your initials are required to release the following information:

____ Mental Health Records (excluding psychotherapy notes)
____ Drug, Alcohol, or Substance Abuse Records
____ Genetic Information (including Genetic Test Results)
____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of death of the individual; the individual reaching the age of maturity; or permission is withdrawn; or the following specific date (optional):

Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving the written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____

Signature of Individual or Individual's Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ____ Parent of Minor ____ Guardian ____ Other

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code §32.003).

SIGNATURE X _____ _____

Signature of Minor Individual Date

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with the Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health and Safety Code, Chapter 181). **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b), (c), § 241.153; 45 C.F.R. §§(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions – In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released – If "All Health Information" is selected for the release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records – This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.066(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified service organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes – If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code § 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form – This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges – Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.