Kristina Fernandez, M.A., L.P.C.-supervisor
9950 Cypresswood, #355
Houston, TX 77070
832-264-4990 cell

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 you 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 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 my 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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Child Psychosocial History

What grade are you in?_____

What school do you attend?_____

Do you have any learning difficulties?_____

_____

Have you repeated any grades?_____

Who lives in your home_____

_____

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_____

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

1._____

2._____

3._____

4._____

5._____

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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?_____

_____

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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?_____