

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 Child's Education:

Age: _____ Grade: _____ Nick Names: _____ Failure or Held Back? _____

What do school personnel tell you about your child? _____

About Your Relationships:

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

Grade	School	Average Grade	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

About Your Child's Family:

Relatives	Name	Age/Grade	Does child get along well with this person?	Occupation
Father				
Mother				
Brother(s)				
Sister (s)				
Step mother				
Step Sister (s)				
Step Brother (s)				
List all people who live in the home with this child:				

Dr. Kimberly Joiner King

About Your Child's Routine

What kinds of physical exercise does your child get? _____

How much coffee, cola, tea, or other caffeine does your child consume each day _____

Is your child's eating restricted in any way? How? Why? _____

Bedtime: _____ Wake-up Time: _____ Hours of sleep on an average night: _____

Does your child have any problems getting enough sleep? _____ (Please describe fully.) _____

About Your Child's Health

Who is your child's pediatrician? _____ When was the last visit? _____

Any Concerns shared by the doctor? _____

Starting with birth and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had.

Describe any allergies your child has: _____

List all medications or drugs your child takes or has taken in the last year—prescribed, over-the-counter, and others. Include dosages please _____

List all prior counselors/dates/reasons: _____

Anything else you are concerned about? _____

(These Questions are regarding older children)

Is this child in a gang? _____ Has this child used drugs? _____. If so, describe which drugs, frequency, age at first use, and amounts _____

Has this child ever been pregnant or fathered a child? _____ If yes, please tell what happened with each pregnancy: _____

Dr. Kimberly Joiner King

Agreement for Therapy with a Minor:

I, _____, the parent/legal guardian of the minor, _____,

- Give my permission for this minor to receive therapeutic services provided through Dr. Kimberly Joiner King.
- I have read, understood, and signed the informed consent related to my child's therapist and I understand the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his or her family.
- Furthermore, I understand that I am expected to participate in this process by meeting with the therapist at least once per month while my child is in therapy.

My signature below means that I understand and agree with all of the points above.

Signature of parent/guardian

Date

Dr. Kimberly Joiner King

About Your Child's Symptoms

Please mark all of the items that apply to your child. Feel free to add any others at the end under "Any other characteristics."

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Accident-prone | <input type="checkbox"/> Fantasy life | <input type="checkbox"/> Mute, refuses to speak | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Fearful | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Slow-moving |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Feelings are easily hurt | <input type="checkbox"/> Name calling | <input type="checkbox"/> Slow-responding |
| <input type="checkbox"/> Argues | <input type="checkbox"/> Fidgety | <input type="checkbox"/> Needs for high degree of supervision | <input type="checkbox"/> Smart-alecky |
| <input type="checkbox"/> Assaults | <input type="checkbox"/> Fighting | <input type="checkbox"/> Negativism | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Bathroom language | <input type="checkbox"/> Finger sucking | <input type="checkbox"/> Nervous | <input type="checkbox"/> Social |
| <input type="checkbox"/> Bigoted | <input type="checkbox"/> Fire setting | <input type="checkbox"/> New school | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Bossy to others | <input type="checkbox"/> Friendly | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Breaks rules | <input type="checkbox"/> Hair chewing | <input type="checkbox"/> Noisy | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Breaks the law | <input type="checkbox"/> Head banging | <input type="checkbox"/> Noncompliant | <input type="checkbox"/> Suicide talk or attempt |
| <input type="checkbox"/> Bullied by others | <input type="checkbox"/> Hitting | <input type="checkbox"/> Obedient | <input type="checkbox"/> Swearing |
| <input type="checkbox"/> Bullies others | <input type="checkbox"/> Hostile | <input type="checkbox"/> Obesity | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Cheats | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Only younger playmates | <input type="checkbox"/> Talks out |
| <input type="checkbox"/> Clowns around | <input type="checkbox"/> Hypochondriac | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Teased |
| <input type="checkbox"/> Competition | <input type="checkbox"/> Imaginary playmates | <input type="checkbox"/> Outgoing | <input type="checkbox"/> Teases others |
| <input type="checkbox"/> Complains | <input type="checkbox"/> Immature | <input type="checkbox"/> Out-of-seat behaviors | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Complains of feeling sick | <input type="checkbox"/> Inappropriate sexual behaviors | <input type="checkbox"/> Overactive | <input type="checkbox"/> Threatens |
| <input type="checkbox"/> Compliant | <input type="checkbox"/> Inattentive | <input type="checkbox"/> Picks on others | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Concern for others | <input type="checkbox"/> Independent | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Tics-movements or noises |
| <input type="checkbox"/> Conflicts at school | <input type="checkbox"/> Inflicts pain on others | <input type="checkbox"/> Pouts | <input type="checkbox"/> Timid |
| <input type="checkbox"/> Conflicts at home | <input type="checkbox"/> Insults others | <input type="checkbox"/> Prejudiced | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Conflicts with friends | <input type="checkbox"/> Interrupts | <input type="checkbox"/> Procrastinates | <input type="checkbox"/> Uncooperative |
| <input type="checkbox"/> Conflicts with police | <input type="checkbox"/> Intimidated by others | <input type="checkbox"/> Provokes others | <input type="checkbox"/> Uncoordinated |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Intimidates others | <input type="checkbox"/> Rages | <input type="checkbox"/> Under-active |
| <input type="checkbox"/> Cruel to animals | <input type="checkbox"/> Intolerant | <input type="checkbox"/> Recent move | <input type="checkbox"/> Unhappy |
| <input type="checkbox"/> Dares others | <input type="checkbox"/> Irritability | <input type="checkbox"/> Refuses | <input type="checkbox"/> Unprepared |
| <input type="checkbox"/> Dawdles | <input type="checkbox"/> Isolates | <input type="checkbox"/> Relationships with friends | <input type="checkbox"/> Vandalism |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Lacks organization | <input type="checkbox"/> Relationships with siblings | <input type="checkbox"/> Violent |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Lacks respect for authority | <input type="checkbox"/> Relationships with teachers | <input type="checkbox"/> Wastes time |
| <input type="checkbox"/> Dependent | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Resists | <input type="checkbox"/> Wetting /soiling of bed
/clothes |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Legal difficulties | <input type="checkbox"/> Responsible | <input type="checkbox"/> Withdraws |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Restless | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Difficulties w/ parent's partner | <input type="checkbox"/> Likes to be alone | <input type="checkbox"/> Rocking or other repetitive movements | <input type="checkbox"/> Yells |
| <input type="checkbox"/> Disobedient | <input type="checkbox"/> Loitering | <input type="checkbox"/> Runs away | <input type="checkbox"/> Any other characteristics: |
| <input type="checkbox"/> Disrupts family activities | <input type="checkbox"/> Loss of friends | <input type="checkbox"/> Sad | <input type="checkbox"/> Other Concerns: _____ |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Low frustration tolerance | <input type="checkbox"/> School avoiding | _____ |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Lying | <input type="checkbox"/> Self-harming behaviors | _____ |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Manipulates | <input type="checkbox"/> Sexual preoccupation | _____ |
| <input type="checkbox"/> Drug sales | <input type="checkbox"/> Masturbation | <input type="checkbox"/> Sexually active | _____ |
| <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Mental retardation | | |
| <input type="checkbox"/> Failure in school | <input type="checkbox"/> Moody | | |

Dr. Kimberly Joiner King

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

Please Read and Initial Each Statement:

- ___ I understand that Kimberly Joiner 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 Joiner 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 Joiner King about this.
- ___ I understand that Kimberly Joiner King can perform some testing and will refer out for testing she is not authorized to give in the state of Texas.
- ___ 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 Joiner King to tell someone else in writing or verbally, b) Kimberly Joiner 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 will notify Child Protective Services.
- ___ 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 Joiner King and I wish to file a formal complaint I may contact the Texas State Board of Examiners for Licensed Professional Counselors at (512) 834-6658.
- ___ I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to Kimberly Joiner 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 \$120.00. These fees are for a play therapy session of 45 minutes and an individual session of 50 minutes.
- ___ I understand that Kimberly Joiner 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.

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 Joiner 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

Notice of Privacy Practices

Dr. Kimberly Joiner King - Trophy Club, Texas

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Department of Health and Human Services.

You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice. The Notice of Privacy Practices is effective as of April 14, 2003

THIS IS YOUR COPY TO KEEP

Dr. Kimberly Joiner King

Acknowledgement of Receipt Of Notice of Privacy Practices For Dr. Kimberly Joiner King

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

Patient: _____ Date: _____

(If patient is a minor, Parent or guardian must sign)

Consent For use and Disclosure of Health Information

I hereby permit Dr. Kimberly Joiner King to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

Patient Signature: _____ Date: _____

(Parent or Guardian if Patient is a Minor)

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Please see our Notice of Privacy Practices for more complete description. You will find this Notice of Privacy Practices on our website at www.drkimberlyking.com and in a notebook in the waiting room. This Notice of Privacy Practices is also provided to you in your intake packet. If this consent is revised in the future, you may obtain a revised copy from this office.