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

ALL ABOUT HER

About Her 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 Her 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 Her 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 Her 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. ____________________

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Dr. Kimberly Joiner King

About Her 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: ____________________

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Dr. Kimberly Joiner King

About His Concerns

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- ❑ Other Concerns: ____________________

____

____

____

____

____

Dr. Kimberly Joiner King

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

This is for HER to 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

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

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 it's 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

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.