

# Austin Marriage and Family Counseling

## NEW PATIENT FORM

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONES: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

MARITAL STATUS: SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ # OF CHILDREN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ ADDRESS \_\_\_\_\_

REFERRED BY \_\_\_\_\_ MAY I THANK THEM? YES \_\_\_\_\_ NO \_\_\_\_\_ SIGN \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHALL I CONTACT? \_\_\_\_\_

PRIMARY CARE M.D. \_\_\_\_\_

DOCTOR'S PHONE \_\_\_\_\_ MAY I CONTACT? YES \_\_\_\_\_ NO \_\_\_\_\_ SIGN \_\_\_\_\_

WHAT MEDS DO YOU TAKE? \_\_\_\_\_

MEDICAL PROBLEMS? \_\_\_\_\_

ALLERGIES? \_\_\_\_\_

PRIMARY REASON FOR SEEKING TREATMENT \_\_\_\_\_

HAVE YOU EVER FELT SUICIDAL? \_\_\_\_\_ HOMICIDAL? \_\_\_\_\_

PROBLEMS WITH ANGER? \_\_\_\_\_ ANXIETY? \_\_\_\_\_ SELF-ESTEEM? \_\_\_\_\_

ALCOHOL? \_\_\_\_\_ DRUGS? \_\_\_\_\_ FOOD? \_\_\_\_\_

SHOPPING? \_\_\_\_\_ GAMBLING? \_\_\_\_\_ PHOBIAS? \_\_\_\_\_

SLEEP? \_\_\_\_\_ LEGAL? \_\_\_\_\_ DIVORCE? \_\_\_\_\_

SEXUAL DYSFUNCTION? \_\_\_\_\_ GRIEF/MOURNING? \_\_\_\_\_

HAVE YOU EVER BEEN ABUSED? \_\_\_\_\_

OTHER PROBLEMS? \_\_\_\_\_

*THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM*

**LYNN EASTER HEAD, BSN, RN, MED, LPC-S, BCPC**

15808 RR 620 North, Suite 212

Austin, Texas 78717

214-502-9081

512-878-3452

[www.AustinMarriageFamilyCounseling.com](http://www.AustinMarriageFamilyCounseling.com)

Leh1@sbcglobal.net

# Austin Marriage and Family Counseling

## Description of Services:

**Lynne Easter Head** is a Registered Nurse and a Licensed Professional Counselor who specializes in individual, marital and family therapy. Ms. Head has twenty-five plus years of experience in the behavioral/medical field. She is a member of the American Counseling Association, the American Psychiatric Nurses Association and the Texas Mental Health Counselors Association. She has served on the board of Galaxy Counseling Center and chaired the TMHCA Political Networking Committee. In addition to psychotherapy with individuals, couples, families and groups, Ms. Head performs psychological assessments, evaluations and diagnosis. She works with all ages in therapeutic treatment from children and adolescents to adults. Brief and intermediate-term psychotherapy and behavior modification is conducted utilizing a systems approach to cognitive/affective/behavioral/developmental/Adlerian framework. Issues such as anxiety, depression, self-esteem, gender dysphoria, addictive behavior, sexual dysfunction, parenting, relationship skills, eating disorders, family negotiation, anger management and stress reduction are some of the service areas available.

## Appointments:

If you are unable to keep an appointment, please give the office at least a 24-hour notice. This is considered a professional courtesy. Appointments cancelled later than this will be charged the regular office visit fee. You may call the office 24-hours a day, including weekends, with any necessary schedule changes.

## Fees/Payment:

Sessions are scheduled for fifty (50) minutes. Payment of the session fee is expected at the time services are rendered. A monthly statement will be provided upon request for presentation to your insurance carrier for possible out-of-network reimbursement. There is a \$35.00 charge for all returned checks. There is a \$85.00 charge per hour for any letters, reports or collateral contacts on your behalf.

## Questions:

Any questions about goals of therapy, length of treatment, therapeutic rationale of prescribed intervention(s), and concomitant risks, alternate choices, and/or therapy termination are welcome and will be discussed at the beginning of our work together. Patients are encouraged to voice any questions or concerns to Ms. Head if/as such arise(s).

## Confidentiality:

Your communications in therapy are completely confidential. However, there are a few possible exceptions to therapist-patient confidentiality/privilege: Communications to qualified legal/medical personnel if a patient threatens imminent, physical or emotional harm to self or imminent physical harm to another identified person; if a patient abuses a child, elderly person, disabled person in any way; if a patient is in a custody battle; if a patient uses therapy to evade arrest for a crime; if a patient discloses confidential therapy information relating to his/her condition as a part of a claim or defense regarding such; in a court ordered examination; to a governmental agency or an official legislative inquiry as required by law; to insurance company personnel as necessary to process insurance/EAP/PPO/HMO claims for services rendered; in civil or criminal actions as allowed by law or ordered by the judge; when proceedings are brought by the patient against a professional; when the patient waives his/her rights in writing; when a professional collection agency is employed in collecting fees for services rendered; or, to patient's personal representative if the patient is deceased.

**Your signature indicates that you have read this document, understand it and consent to provisions therein.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

No records to be kept \_\_\_\_\_ Date \_\_\_\_\_

**LYNN EASTER HEAD, BSN, RN, MED, LPC-S, BCPC**

15808 RR 620 North, Suite 212  
Austin, Texas 78717

214-502-9081

512-878-3452

[www.AustinMarriageFamilyCounseling.com](http://www.AustinMarriageFamilyCounseling.com)

[Leh1@sbcglobal.net](mailto:Leh1@sbcglobal.net)

# Austin Marriage and Family Counseling

## CONSENT FORM

*I, \_\_\_\_\_, consent to the release of privileged information and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation, and authorize my therapist, Lynne Easter Head, BSN, RN, MED, LPC-S, BCPC, and*

\_\_\_\_\_

\_\_\_\_\_

*to exchange any information for the purpose of clarifying and enhancing my care and treatment.*

*Lynne Easter Head, and others listed above, are hereby released from all liability arising out of, or in any way incidental to, producing records or providing information according to this authorization.*

*A duplicate, photostatic copy or facsimile reproduction of this document may be used in lieu of the original.*

*This authorization is subject to revocation in writing by the undersigned.*

*Signed* \_\_\_\_\_

*Date* \_\_\_\_\_

*Witness* \_\_\_\_\_

**LYNN EASTER HEAD, BSN, RN, MED, LPC-S, BCPC**

15808 RR 620 North, Suite 212  
Austin, Texas 78717  
214-502-9081  
512-878-3452

[www.AustinMarriageFamilyCounseling.com](http://www.AustinMarriageFamilyCounseling.com)  
Leh1@sbcglobal.net

# Austin Marriage and Family Counseling

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

OCCUPATION \_\_\_\_\_

MY EPITAPH WOULD READ \_\_\_\_\_

THE WORST JOB I'VE EVER HAD \_\_\_\_\_

MY FAVORITE AUTHORS \_\_\_\_\_

MY PET PEEVE \_\_\_\_\_

I'M PROUDEST OF \_\_\_\_\_

MY BIGGEST DISAPPOINTMENT \_\_\_\_\_

MY FAVORITE KIND OF MUSIC \_\_\_\_\_

MY IDEAL VACATION \_\_\_\_\_

BEST ADVICE FOR SOMEONE 10 YEARS YOUNGER THAN ME \_\_\_\_\_

BIGGEST HONOR I'VE EVER RECEIVED \_\_\_\_\_

MY MOST EMBARRASSING MOMENT \_\_\_\_\_

I'M ALLERGIC TO \_\_\_\_\_

MY FAVORITE DRINK \_\_\_\_\_

MY FAVORITE PERFORMER \_\_\_\_\_

I'M CURRENTLY READING \_\_\_\_\_

I HAVE A PHOBIA ABOUT \_\_\_\_\_

I'M SUPERSTITIOUS ABOUT \_\_\_\_\_

MY FRIENDS LIKE ME BECAUSE \_\_\_\_\_

GUESTS AT MY FANTASY PARTY \_\_\_\_\_

MY HEROES \_\_\_\_\_

BEHIND MY BACK, PEOPLE SAY \_\_\_\_\_

**LYNN EASTER HEAD, BSN, RN, MED, LPC-S, BCPC**

15808 RR 620 North, Suite 212  
Austin, Texas 78717

214-502-9081

512-878-3452

[www.AustinMarriageFamilyCounseling.com](http://www.AustinMarriageFamilyCounseling.com)

[Leh1@sbcglobal.net](mailto:Leh1@sbcglobal.net)

# Austin Marriage and Family Counseling

## NOTICE OF PRIVACY PRACTICE

The Department of Health and Human Services has established a **Privacy Rule** to help ensure that personal information is protected for privacy. The **Privacy Rule** was also created in order to provide a standard for healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient, to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical information and will do all we can to take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum information to only those we think are in need of your healthcare information, to provide you with the most effective care. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships for your benefit (such as laboratories or other clinicians) to provide continuity of care.

You may refuse in writing to consent to the use or disclosure of your Personal Health Information (PHI). Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future date you may request to refuse disclosure of all or part of your PHI, however, you may not revoke actions that have already been taken which relied upon this, or a previously signed, consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed this privacy notice.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**LYNN EASTER HEAD, BSN, RN, MED, LPC-S, BCPC**

15808 RR 620 North, Suite 212  
Austin, Texas 78717  
214-502-9081  
512-878-3452

[www.AustinMarriageFamilyCounseling.com](http://www.AustinMarriageFamilyCounseling.com)  
[Leh1@sbcglobal.net](mailto:Leh1@sbcglobal.net)