900 Lovett Boulevard
Houston, TX 77006
713-470-9878
www.klaybors.com
www.klaybor.blogspot.com

Klaybor&Klaybor
psychotherapy services

Registration Form

Name:_____

Home Phone:_____ **Cell Phone:**_____

Email:_____ **Work Phone:**_____

Home Address:_____

City:_____ **State:**_____ **Zip:**_____

_____**Male** _____**Female** **Birth Date:**_____ **Age:**_____ **SS#:**_____

Relationship Status: ____**Single**____**Married**____**Widowed** ___**Separated**___**Divorced** ____**Living with partner**

Spouse/Partner's Name_____

Your Employer:_____ **Occupation:**_____

Whom may we thank for referring you?_____

In case of emergency, who should be notified?_____ **Phone:**_____

We have an automated appointment reminder system. ***You will receive a reminder via TEXT.***
Please check any other options that apply:

☐ **Do not send a reminder** ☐ **Do not contact by phone**

☐ **Do not send a text** ☐ **Do not contact by email**

Other than myself, _____**is given the right to receive information or make my appointments.**

CANCELLATION POLICY

Cancellation of an appointment requires 24-hour notification. **Late cancellations will be charged directly to the patient. A signature below indicates that you understand and accept these conditions.**

PRACTICES

I understand that as part of my health care, Klaybor and Klaybor Psychotherapy Services originated and maintain paper and/or electronic records describing my health history, symptoms, diagnosis, mental health treatment and any plans for future treatment.

_____ _____

Signature **Date**

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Informed Consent

Welcome to our psychotherapy practice. This document contains important information about our professional services and policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

I understand that:

All files are kept confidential. A written consent is required to release any information regarding my treatment to any other person, organization, or agency except in the rare case of a court order, child abuse, life-threatening situations and national security issues.

- We are HIPAA compliant with all of our records being secured,
- Certain mental disorders and emotional conditions can have medical causes and in such cases, a physician consult is essential,
- I agree to participate in the necessary therapy through the course of assessment and treatment,
- I am aware that I have the right to discontinue treatment at any time except in the case where assessment or treatment, have been court ordered,
- I am also aware that my therapist has the right to discontinue treatment if it is clear that I am not benefiting,
- Psychotherapy requires participation and cooperation from the patient. Your effort will play an important role in determining the benefits you receive. Honest communication is an important part of therapy and I will expect you to feel free to discuss any questions or concerns you may have.
- We are not on any insurance panels, thus, all fees are due at the time of service,
- Receipts can be generated by request for filing for out or network benefits,
- 24-hour notice is required for cancellations. Missed appointments are charged,
- I hereby consent to engaging in psychotherapy and counseling services with ***Klaybor and Klaybor Psychotherapy Services.***

_____ _____

Patient Signature **Date**