Desoto Family Counseling
& Pediatric Therapy Center

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JANUARY 2027 PATIENT UPDATE FORM

We are glad you have chosen to continue being one of our patients. **PLEASE** complete each section to the best of your ability. We value our patients and want to ensure you are given the **best care possible**.

[PATIENT INFORMATION]

LAST NAME_____ FIRST NAME _____ MI _____

DATE OF BIRTH _____ | _____ | _____ SOCIAL SECURITY # _____ | _____ | _____

GENDER [MALE] [FEMALE] [PREFER NOT TO SAY] ADDRESS _____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS - [SINGLE] [MARRIED] [WIDOWED] [DIVORCED] [SEPARATED] SPOUSE NAME [IF MARRIED] _____

EMAIL ADDRESS: _____ CELL # _____ | _____ | _____

MAILING ADDRESS [if different]: _____

[FINANCIALLY RESPONSIBLE PARTY - IF OTHER THAN PATIENT]

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____ | _____ | _____ SEX [MALE] [FEMALE]

LAST NAME _____ FIRST NAME _____ MI _____

SOCIAL SECURITY # _____ | _____ | _____ PHONE # _____ | _____ | _____

[INSURANCE INFORMATION]

PRIMARY _____ SECONDARY [IF APPLICABLE] _____

PRIMARY ID _____ GROUP #_____ SECONDARY ID _____GROUP # _____

[SUBSCRIBER INFORMATION - IF OTHER THAN PATIENT]

LAST NAME _____ FIRST NAME _____ MI _____

DATE OF BIRTH _____ | _____ | _____ SOCIAL SECURITY # _____ | _____ | _____ SEX [MALE] [FEMALE]

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____ CELL # _____ | _____ | _____

[EMERGENCY CONTACT INFORMATION]

NAME _____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ | _____ | _____ PHONE # _____ | _____ | _____

By signing below, I am confirming that all the information I have provided is true to the best of my knowledge.

_____ _____

PATIENT OR PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

UPDATE OF POLICIES

IMPORTANT POLICY TO REVIEW: All DFCPTC's policies were reviewed and signed at your/your child's first appointment. The appointment policy is especially important and has been placed here for your review.

[APPOINTMENT POLICY]

Our office policy requires ALL appointments needing to be cancelled and/or rescheduled by 1:00 PM the day PRIOR to your appointment. We have this policy set in place so that our providers are given the opportunity to fill in any cancellations that may arise. If a patient cancels and/or reschedules an appointment LATER THAN 1:00 PM the day PRIOR to their appointment – that will be considered a LATE CANCELLATION. If a patient fails to cancel an appointment at all – this will be considered a NO SHOW. We also have a grace-period in which a patient may arrive at the appointment and still be seen. The grace period is as follows:

- Counseling, Occupational, and Physical Therapy has a 20-minute grace period.
- Medication Management has a 10-minute grace period.
- Speech Therapy is based on your scheduled appointment time. Please see your provider for additional information.

If a patient arrives after the grace period, the patient will not be seen by the provider. If a patient consistently arrives to their appointments late but within the grace period, their provider will address this issue with them. Our policy is that if a client accumulates 2 consecutive late cancellations/no shows or 4 total late cancellations/no shows in a 12-month period beginning at the initial appointment, the provider then has the right to refer the patient to another mental health facility and terminate services within Desoto Family Counseling and Pediatric Therapy Center. If a patient ever wants to dispute that an appointment was cancelled within the time stated by our policy, we ask that you address the matter with your provider and in turn the solution can be passed on to our front staff.

If you have read, and agree to, all the terms regarding our appointment cancellation policy please sign below.

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PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

IMPORTANT POLICY TO REVIEW: [ETHICS, CLIENT WELFARE, AND SAFETY]

All counseling sessions will be rendered in a professional manner consistent with the ethical standards of the American Counseling Association and/or the National Association of Social Workers. If at any time you feel that the provider is not performing in an ethical or professional manner, we ask that you please let staff know. If we are unable to resolve your concern, DFCPTC staff will provide you with information to contact the professional licensing board that governs counselors. Due to the very nature of psychotherapy, as much as we would like to guarantee specific results regarding your therapeutic goals, we are unable to do so. However, with your consistent participation, our office will work to achieve the best possible results for you or your child. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is our intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility, nonetheless.

It is DFCPTC policy that the parent or guardian of any client who is age 12 or younger may not, for any reason, leave the premises while the client is being seen for a session. Additionally, no child under 12 may be left unattended in any area of DFCPTC. For the safety of all our clients, their accompanying family members, and children, our office maintains a zero-tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. DFCPTC reserves the right to contact law enforcement officials and/or terminate treatment with any client who violates our office weapons policy.

If you have read and agree to follow all terms and guidelines referring to client welfare here at Desoto Family Counseling and Pediatric Therapy Center, please sign below.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____

NEW POLICY TO REVIEW:[IMPORTANCE OF INSURANCE TRANSPARENCY]

At Desoto Family Counseling and Pediatric Therapy Center, we strive to provide you with the best care that you, your family, or your child may need. It's imperative that you disclose all insurances that you or your child holds in order to help us give you the best care that we can. The type of insurance that you have dictates which providers are available to you or your child, since not all of our providers are able to take all forms of insurance. When a client fails to tell us about all insurances that they have, the following unfortunate things could occur: insurance billing could be disrupted, services could be paused due to billing being disrupted, the client could have to change providers in the midst of services, etc. If the billing department receives a denial and/or requests a clarification of benefits, services may be paused until clarification has been received or the denied claim has been paid. If a client is unreachable in the event of insurance billing denials, they may be held responsible for the payments.

PLEASE INITIAL:

_____ I understand the importance of disclosing ALL insurance information and agree to disclose all insurance information.

_____ I understand that services could be disrupted due to insurance billing difficulties related to primary/secondary insurance confusion.

Client Name: _____ Client Signature: _____

ESTABLISHED POLICIES: Below is a list of the policies that you have already read and signed at the time you began services with us. ***If you would like a printed copy of all our policies from the new patient paperwork that you filled out, we will provide this for you today. Please ask the front desk staff.***

Authorization to release medical information and payment of insurance benefits; financial guidelines; patient communication guidelines; statement to permit payment of Medicare benefits to physicians; technology guidelines; decision to terminate policy; acknowledgment of privacy practices; clients with divorced parents or guardians policy; our Fee Schedule policy; patient communication policy; authorization to release limited information; ethics, client welfare, and safety; communication response time; acknowledge of telemental health policy; confidentiality and records; duty to update insurance information; and release of information for family and or friends of the client.

If you have read and agree to the above list of the established policies, please sign below.

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____