

# Woodlands Family Institute, P.C.

Stephen Parham, PhD  
Psychologist

## PERSONAL DATA RECORD

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

SSN \_\_\_\_\_ TXDL \_\_\_\_\_

Employer/School/Address \_\_\_\_\_

### May we leave a message at any of the following?

Home phone (circle one) \_\_\_\_\_ Yes No

Work phone (circle one) \_\_\_\_\_ Yes No

Cell phone (circle one) \_\_\_\_\_ Yes No

Unencrypted email address \_\_\_\_\_ Yes No

**\* Please do not cancel appointments via email. You must contact the office directly.**

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other \_\_\_\_\_

**Referred** to our office by \_\_\_\_\_

May we send a **thank you** to the person who referred you? (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

### Credit Card Payment Authorization for Auto Charge

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

MC/VISA No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name as listed on Card \_\_\_\_\_

Signature of Authorized User \_\_\_\_\_

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## Financial Responsibility

Name of person(s) financially responsible for this account \_\_\_\_\_

Address/phone if different from client \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature(s) \_\_\_\_\_

Relationship to client \_\_\_\_\_

## Emergency Contact

Name \_\_\_\_\_ Phone \_\_\_\_\_

Alternate phone \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Relationship to client \_\_\_\_\_

**You may change the above instructions at any time by requesting another form or otherwise instructing in writing.**

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## ACKNOWLEDGEMENT

I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies**. I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

\_\_\_\_\_  
Client or Authorized Representative Signature

\_\_\_\_\_  
Date

Refuse to Sign \_\_\_\_\_

Unable to Sign (specify reason) \_\_\_\_\_

\_\_\_\_\_  
Signature of Person Documenting Refusal or Inability to Sign

\_\_\_\_\_  
Date

## Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

**After reading the agreements, please ask about any part of the agreement that you do not understand.**

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## *Information, Policies, and Consent*

We are very honored that you have selected Woodlands Family Institute to provide counseling or psychological services. All of us wish to do our best to assist you in making this experience meaningful and fruitful. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

Practicing independently since 1983, I hold the degree of Ph.D. in Psychology and am licensed by the State of Texas as a Psychologist, Professional Counselor, and Marriage/Family Therapist. Additionally I am listed as a Health Service Provider in Psychology at the State and National levels. I hold an abiding belief that no matter how difficult a person's circumstances may be, it is possible to produce meaningful changes. Sometimes this takes a long time to achieve. While some clients need only a few sessions to reach their goals, others may require months or even years. This is truly an individual quest. As a client, you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you feel confident to carry on without my intervention.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be as safe and secure as possible so that we concentrate exclusively on your concerns. You are best served by experiencing me in my professional role. If at anytime you are dissatisfied with my services, please let me know.

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Children can be joyful and energetic, but with respect to the concerns which brought you to us, we request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results for you.

Please be aware that I do *not* provide consultation, evaluation, or legal testimony in child custody, child visitation, or molestation cases. If you require these services, I will be happy to refer you to professionals who work with these issues.

## *Office Policies*

### 1. Initial

**Payment Policy:** Payment is due in full at time of service. Please make out your check before the session begins. Visa & Mastercard are also accepted. It is not our policy to carry balances forward. We expect balances for “forgotten checkbooks” or “forgotten appointments” to be made up promptly or by the next regularly scheduled appointment at the latest. If an outstanding balance accrues, you will be billed on the first of the month and assessed a 2% finance charge, compounded monthly. There is a \$10.00 rebilling for every statement sent out after the first billing. There is also a \$15.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and could impact your credit rating.

**Session fee:** \$175.00 (45 minute duration)

**After hour’s session fee:** \$270.00 per session.

**Miscellaneous:** Charges for other professional services are prorated on the basis of \$175.00 per hour, 15 minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is prorated at the rate of \$175.00 per hour, “portal to portal”, that is, for the time I am out of the office on your behalf.

**Legal testimony:** Please be advised that I do not provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be so ordered, fees will be charged at

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the rate of \$750.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. Records review; consultation with clients, litigants, attorneys (in person or via phone or by email); reports; waiting at court; or any other service provided will be charged at the rate of \$175.00 per hour or prorated accordingly. These fees are **payable in advance**.

## 2. Initial

**Office hours:** Office hours are from 9 a.m. to 8 p.m. Monday, Tuesday, Thursday; and 9 a.m. to 5 p.m. on Friday unless otherwise specified. Any other time is considered "after hours" and will be charged at 1 1/2 times the standard rate. After hours time is generally reserved for family time and self-care.

## 3. Initial

**Cancellations:** The scheduling of an appointment involves the reservation of time specifically for you. Therefore, 24 hours cancellation notice is required so that there will be no charge to your account. **PLEASE CALL THE OFFICE TO CANCEL AN APPOINTMENT. EMAIL IS NOT MONITORED FOR CANCELLATIONS.** If you are unable to meet this time schedule, but we are able to assign your appointment time to another client, you will not be charged. Due to the fact that your appointment is contracted time specifically set-aside for you, cancellations in advance will be appreciated. *Please note that insurance companies do not reimburse for missed appointments.*

## 4. Initial

**Insurance:** Your health insurance policy is a contract between you and your insurance company. I am not a party to that contract. Although I am not listed as a provider on any network panels, benefits are often available for services rendered by "out-of-network" providers. We advise that you contact a company representative to determine how your insurance company will reimburse you. If you elect to seek reimbursement by an insurance carrier for services rendered, we will provide you with a receipt to assist you in completing your insurance claim. We will consult your third-party payer only at your direction with such consultations billed to your account. Some insurance companies reimburse clients for services, and some do not. Those that do usually require a standard amount be paid by you before reimbursement is allowed, and then usually a percentage of the fee is reimbursable. The client remains responsible for payment in full, including any portion not reimbursed by insurance. **Please be aware that: Third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated.**

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Since I do not contract directly with insurance companies, I am responsible and accountable only to you. Thus my loyalties are not divided, and there is no conflict of interest.

The office staff is happy to provide you with insurance ready receipts for filing your claim. WFI does not file out-of-network insurance claims.

## 5. Initial

**Confidentiality:** The law protects the privacy of all communications between a client and psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by federal and state law. There are other situations that require only that you provide advanced written consent. Your signature on our *Acknowledgment* form provides consent for those activities, as follows:

You should be aware that we practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions, unless it seems important to our work together. If you would prefer this to be handled differently, please let us know. All administrative staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

We also have contracts with some business services, such as an answering service, electronic claims processing service, and managed care organizations. As required by federal law, we have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. Details of these contracts are available upon request.

I will keep confidential anything you say to me, with the following exceptions: a) you direct me to tell someone else; b) I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose abuse or neglect of children, the elderly, or disabled persons; e) you disclose sexual mistreatment by another therapist; f) the need to

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release information to other professionals involved in your treatment; g) in proceedings in which a claim is made about one's physical, emotional, or mental condition; h) when disclosure is relevant in any suit affecting the parent-child relationship; i) where otherwise legally required. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties. **Again, please note: Third-party insurance companies require submission of diagnosis and specific clinical data. If you elect to use insurance or managed care to cover part of the cost of your sessions, please be aware that I may be required to provide that information.**

6. Initial

**Emergency services:** It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for clients' day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that an emergency occurs, leave a message with the answering service, making sure to state that your call is an emergency. We will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. We can be reached at 281-363-4220 or 713-866-4494. If we are unable to respond quickly enough, please call 911 or your local emergency room.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

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**Signature**

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**Date**

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## CONSENT FOR TREATMENT

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I give full consent for myself, my child/adolescent or dependent due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

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## PSYCHOSOCIAL HISTORY

Date \_\_\_\_\_

Name of Patient \_\_\_\_\_

Date of birth \_\_\_\_\_

### Presenting Problems:

- Recent life transition
- Depression, isolation, withdrawal
- Suicide gesture, attempt or ideation
- Homicidal ideation
- Self-abusive behavior
- Abuse (physical, emotional, sexual)
- History of traumatic life events (in addition to the previous)
- Neglect, abandonment
- Marginal to low IQ
- Difficulty at school or work
- Difficulty with authority
- Commits unlawful acts
- Under socialized (difficulty making friends)
- Anger outbursts/rage
- Runaway from home or placement
- Impulse control problems
- Low self-esteem
- Physically aggressive
- Destruction of property
- Sexual dysfunction
- Does not feel guilty about wrongdoing
- Paranoid thoughts, delusions
- Hallucinations (auditory, visual, tactile)
- Gender identity problems
- Excessive worry, racing thoughts, obsessions
- Compulsive behavior
- Substance abuse

Have you had any **treatment** for these problems before today?      Y      N

If yes, when? Where? Who was your doctor or therapist?

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## History of psychiatric hospitalizations

Date \_\_\_\_\_ Location \_\_\_\_\_ Outcome \_\_\_\_\_

Date \_\_\_\_\_ Location \_\_\_\_\_ Outcome \_\_\_\_\_

Date \_\_\_\_\_ Location \_\_\_\_\_ Outcome \_\_\_\_\_

## Family past psychiatric history

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## Family medical history

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## Personal past medical history

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## Drug and Alcohol Abuse

Any **family** history of drug and/or alcohol usage? Please list and describe \_\_\_\_\_

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Any **personal** history of drug/alcohol usage? List and describe \_\_\_\_\_

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**Family History (include spouse, significant other, children, parents, step families, adoption history, etc.)**

Name	Relationship	Age	Living where?

**Marital status of patient**

Married \_\_\_\_\_ How long \_\_\_\_\_

Divorced \_\_\_\_\_ How long ago \_\_\_\_\_

Separated \_\_\_\_\_ How long ago \_\_\_\_\_

Widow/widower \_\_\_\_\_ How long ago \_\_\_\_\_

Other \_\_\_\_\_

**Other significant adults or children in patient's life** (Please include type of relationship-e.g. supportive, conflictual, etc.)

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## Traumatizing Life Events

Have you experienced any history of significant abuse (physical, emotional or sexual)?

Please briefly describe \_\_\_\_\_

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Any history of **significant life events** such as deaths, separation from parent(s), frequent moves, terminal illnesses in the family or close friendship?

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## Cultural Influences

With what ethnic/cultural groups do you personally identify? \_\_\_\_\_

With what ethnic/cultural group does your family most identify? \_\_\_\_\_

Describe any cultural values or beliefs that may impact treatment \_\_\_\_\_

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## Educational History

Highest degree earned \_\_\_\_\_

Current School attending \_\_\_\_\_ Grade \_\_\_\_\_

Average grade performance \_\_\_\_\_

Overall motivation to attend school \_\_\_\_\_

Extracurricular activities \_\_\_\_\_

## Employment History

Present employment status-where-how long? \_\_\_\_\_

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Positive/negative aspects of current position \_\_\_\_\_

\_\_\_\_\_

If on leave of absence or disability, will you return to present job? \_\_\_\_\_

\_\_\_\_\_

**Special interests/hobbies/skills**

\_\_\_\_\_

\_\_\_\_\_

**Additional Comments** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**

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## Treatment Plan

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

**Name:** \_\_\_\_\_

### Presenting Problems:

\_\_\_\_ Depression \_\_\_\_ Anxiety \_\_\_\_ Relationship Discord \_\_\_\_ Stress \_\_\_\_ Alcohol  
\_\_\_\_ Drugs \_\_\_\_ Anger \_\_\_\_ Obsessive/Compulsive \_\_\_\_ Bereavement \_\_\_\_ Parenting  
\_\_\_\_ Sexual \_\_\_\_ Psychosis \_\_\_\_ Adjustment Issues \_\_\_\_ School/Work Issues  
\_\_\_\_ Other (please describe)

Description:

### Symptoms:

\_\_\_\_ appetite \_\_\_\_ sleep \_\_\_\_ sadness \_\_\_\_ self-esteem \_\_\_\_ motivation \_\_\_\_ energy  
\_\_\_\_ hygiene \_\_\_\_ agitation \_\_\_\_ hyper \_\_\_\_ worry \_\_\_\_ social isolation \_\_\_\_ tearful  
\_\_\_\_ racing thoughts \_\_\_\_ panic attacks \_\_\_\_ obsessive thoughts \_\_\_\_ compulsive behaviors  
\_\_\_\_ flat emotions \_\_\_\_ concentration \_\_\_\_ memory \_\_\_\_ weight loss/gain \_\_\_\_ confidence  
\_\_\_\_ loneliness \_\_\_\_ excessive emotionality \_\_\_\_ hallucinations \_\_\_\_ delusions  
\_\_\_\_ erratic behavior \_\_\_\_ alcohol/drug dependence \_\_\_\_ other (please describe)

Description:

### Treatment Goals:

1. Reduce frequency and intensity of:
2. Increase frequency and intensity of:
3. Eliminate:

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## Treatment Methods and Duration:

\_\_\_\_ Individual sessions weekly using CBT, EMDR, and/or relaxation techniques

\_\_\_\_ Relationship sessions weekly using CBT and application of research findings

## Diagnosis:

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Axis V \_\_\_\_\_

## Recommendations for Adjunctive Treatment/Assessment:

## Plan Review/Revision:

\_\_\_\_\_  
Stephen Parham, PhD

\_\_\_\_\_  
Client