# D. Scott Stanley, PhD, LMFT, LPC

1458 Campbell Road · Suite 250A
Houston, Texas 77055
Phone: 281.960.3991
Fax: 713.467.6532
Email: scott@dscottstanley.com
www.dscottstanley.com


---

Thank you for choosing me for your psychological health-care. I assure you that I will work with you in a caring and professional manner. Please take a few moments to read my policies and do not hesitate to ask any questions you may have.

## OFFICE HOURS

My office hours fluctuate with my appointments. I will work with you to schedule a mutually agreeable time.

## SESSIONS

Full sessions are 45 – 50 minutes and half sessions are 20 – 25 minutes long. In order to ensure that your time is respected and waiting time does not interrupt your schedule or mine, every effort is made to stop and start on time. Extended sessions can be arranged when necessary. Group sessions are typically 1 ½ hours.

## CANCELLATIONS

There is no charge for missed appointments **if appointments are cancelled at least 48 hours in advance.** Cancellations must be made by phone. **You will be charged for appointments not cancelled 48 hours in advance.** The amount of the charge is my full fee, as insurance does not cover cancelled sessions.

## EMERGENCY SERVICES

Emergency consultation is provided 24 hours each day, seven days a week. I will usually be available to assist you personally. If I am unavailable, you may be referred to one of my colleagues. You may reach me at 281.960.3991. Should I be unavailable for calls, you will be given instructions whom to call. If the consultation requires more than 10 minutes, you may be billed for time.

## NOTICE OF PRIVACY PROCEDURES

I am required to: maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information I collect and maintain about you, abide by the terms of this notice, notify you if I am unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

**FEES**

Payment is due at the time services are rendered. If you are a member of an insurance company for which I am a contracted provider, the fee will be your mental health co-pay. For those patients that belong to an insurance company with whom I am not contracted, I will give you an itemized statement so you may file it with your insurance company and have them reimburse you directly. **Please be advised that if your insurance does not uphold your contract for any reason, you will be responsible for 100% of incurred charges.**

It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 15% charge on the outstanding balance.

There is a $25 fee for all returned checks.

**TYPES OF THERAPY**

A variety of therapies are available depending on your needs and wishes. At your first visit, you and I will evaluate together what issues you wish to address and the type of therapy that would be most appropriate.

Please check each type of therapy you feel may be appropriate:

________ Marriage/Relational Counseling

________ Individual Counseling

________ Parent Consultation

________ Family Therapy

________ Psychological Assessment

________ Low Energy Neurofeedback Systems (LENS)

My goal is that we will develop a positive, rewarding relationship. At this time, please take a few minutes to complete the enclosed information so I may better help you achieve your goals.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE OFFICE POLICIES.

______________________________________________

Client Signature and Date

If the client is a child, this form must be signed by the legal parent or guardian.

# D. Scott Stanley, PhD, LMFT, LPC

1458 Campbell Road · Suite 250A
Houston, Texas 77055
Phone: 281.960.3991
Fax: 713.467.6532
Email: scott@dscottstanley.com
www.dscottstanley.com


---

## Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of this treatment or any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel and do not show up, I will be charged the therapist's full fee for that appointment.

I am aware that an agent of my insurance company or other 3rd party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

________________________________________

Client Signature and Date

________________________________________

Printed Name and Relationship to the Client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

________________________________________

Therapist's Signature and Date

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*

# D. Scott Stanley, PhD, LMFT, LPC

1458 Campbell Road · Suite 250A
Houston, Texas 77055
Phone: 281.960.3991
Fax: 713.467.6532
Email: scott@dscottstanley.com
www.dscottstanley.com


---

## Patient Information Sheet

Date: ____________

Patient's Name: ________________________________________ Birth Date: ________________________

Street Address: ____________________________________________________________________________

City: _________________________________ State: ________ Zip Code: ___________________________

Home Phone: _____________________________ Cell Phone: ___________________________________

Social Security Number: ___________________________ Gender: _______________________________

Employer: __________________________________________________________________________

Business Address: ____________________________________________________________________

Work Phone: ______________________________ Email: ______________________________________

Referred by: ________________________________________________________________________

**Primary Insurance**

Person responsible for account: _______________________________________________________

Date of Birth: ___________________________ Relationship to Patient: ___________________________

Responsible party employer: ________________________________ Work Phone: ____________________

Insurance Company: _________________________________________________________________

Insurance Address: __________________________________________________________________

Insurance Phone: ____________________ Insured ID #: ___________________________________

Group #: _____________________________

**I hereby authorize payment directly to D. Scott Stanley of all benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether paid by insurance, and for all services rendered on my behalf or my dependents.**

__________________________________________________

Signature and Date

D. Scott Stanley, PhD, LMFT, LPC
1458 Campbell Road · Suite 250A
Houston, Texas 77055
Phone: 281.960.3991
Fax: 713.467.6532
Email: scott@dscottstanley.com
www.dscottstanley.com

## Adult Checklist of Concerns

Please mark all the items below that 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. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (or children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy

- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pain
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory Problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Over-sensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns…")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, over-sensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use

- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

- ☐ ____________________________________________
- ☐ ____________________________________________

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

______________________________________________

*This is a strictly confidential medical record. Redisclosure or transfer is expressly prohibited by law.*

# D. Scott Stanley, PhD, LMFT, LPC

1458 Campbell Road · Suite 250A
Houston, Texas 77055
Phone: 281.960.3991
Fax: 713.467.6532
Email: scott@dscottstanley.com
www.dscottstanley.com


## Patient History

1. Have you ever received psychological or psychiatric or counseling services before?

☐ Yes

☐ No

| When? | From whom? | For what? | With what results? |
|---|---|---|---|
| ______ | ______ | ______ | ______ |
| ______ | ______ | ______ | ______ |
| ______ | ______ | ______ | ______ |

2. Have you ever taken medications for psychiatric or emotional problems?

☐ Yes

☐ No

If yes, please indicate:

| Prescription? | From whom? | For what? | With what results? |
|---|---|---|---|
| ______ | ______ | ______ | ______ |
| ______ | ______ | ______ | ______ |
| ______ | ______ | ______ | ______ |

3. Abuse history: ☐ I was not abused in any way ☐ I was abused. If you were abused, please indicate the kind of abuse, who abused you, and when it happened.

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

4. Are you presently suing anyone or thinking of suing anyone? If yes, please explain:

5. Is your reason for coming to see me related to an accident or injury? If yes, please explain:

6. Are you required by a court, the police, or a probation/parole officer to have this appointment? If yes, please explain:

7. Is there anything else that is important for me, as your therapist, to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*

# D. Scott Stanley, PhD, LMFT, LPC

1458 Campbell Road • Suite 250A
Houston, Texas 77055
Phone: 281.960.3991 Fax: 713.467.6532
Email: scott@dscottstanley.com

I, ______________________, hereby authorize D. Scott Stanley, PhD, LMFT, LPC, to charge my credit card account in the amount not to exceed: $ 150.00 .

( ) Visa ( ) MasterCard ( ) AMEX ( ) Discover

Credit Card Number: ___________________________

Expiration Date (MM/YY): _____/_______

VID Code: _________

Credit Card Billing Address:

Street: ______________________________________________

City, State, Zip: ______________________________________

Telephone: _________________________ Email: ___________________________

As the credit card holder, I authorize D. Scott Stanley, PhD, LMFT, LPC to charge my credit card $ 150.00 for any missed appointments or appointments not cancelled within a 24 hour notice. Missed or non-cancelled appointments within 24 hours are not covered by your insurance. You are responsible for the full fee.

________________________________________________________

Cardholder's signature and date