Mark S. Jones, DMin, LPC, LMFT, BCN, QEEGD

16607 Blanco Road, Suite 904, San Antonio, TX 78232

First MI Last Client Name	Gender: Male ☐ Female ☐	Today's Date: ___/___/___
Home Address City, State, Zip	Home Phone # ( ) Cell # ( )	
Email address	Date of Birth ___/___/___	Age
Employer	Occupation	
Business Address City, State, Zip	Business Phone # ( ) Social Security #	
Relational status: ☐ Single ☐ Married ☐ Committed Relationship ☐ Separated ☐ Divorced ☐ Widowed		
Number of persons other than yourself living in your household? Adults: _____ Children: _____		
Method of contact (check all that apply): ☐ home phone ☐cell phone ☐business phone ☐email		

Name of Partner / Spouse / Parent / Guardian Information (circle one)		
First MI Last	Gender: Male ☐ Female ☐	
Home Address City, State, Zip	Home Phone # ( ) Cell # ( )	
Email address	Date of Birth ___/___/___	Age
Employer	Occupation	
Business Address City, State, Zip	Business Phone # ( ) Social Security #	
Method of contact (check all that apply): ☐ home phone ☐cell phone ☐business phone ☐email		

Children's Names	Sex	Age	Descriptive Comment

Are you presently seeing another counselor? Y ☐ N ☐ If yes, whom?
Have you had previous counseling or psychotherapy? Y ☐ N ☐ Where?
Why are you presently seeking counseling?
How did you learn of Mark Jones? ☐ I give my permission for Mark Jones to acknowledge this referral.

Primary Physician:	Phone:
Psychiatrist:	Phone:

Health conditions your counselor should be aware of:

Medications	Dosage	Reason

Insurance company:	Policy holder:	
Policy holder employer:	Policy holder date of birth:	
Policy number:	Group number:	
Policy holder relationship to client: ☐ self ☐ parent ☐ spouse ☐ other (specify):		
Insurance phone number (on card):		
Authorization number:	Copay:	Deductible:

Is this an EAP? : ☐ yes ☐ no
Employee Assistance Programs generally provide their own forms to be completed by you and your therapist. If you do not have prior approval from your EAP, Dr. Jones will charge the standard fee pending reimbursement from your EAP.

CANCELLATION AND MISSED APPOINTMENT POLICY

When you make an appointment for counseling you are reserving that time. If you cancel an appointment without giving adequate notice, that time will be unavailable to others who may need it. Therefore, you may be charged for sessions that you miss, or cancel without giving at least 24 hours notice. Insurance does not pay for a session that is missed.

RETURNED CHECK POLICY

There will be a $25 charge for each returned check or “do not honor” credit card payment.

☐ I want to be on the mailing list to receive newsletters and announcements.

Signature _____ **Date** _____
Client, parent or guardian

Signature _____ **Date** _____
Client, parent or guardian