Biographical, Medical, Contact & Payment Form

Dr. GK Gary G. Kindley
D.Min., LPC, Pastoral Psychotherapist

Biographical Information

NOTE: If you are entering counselling with another person, please complete a separate biographical form for each client.

General Information

Date of Your First Appointment: _____, 20_____

Full Name: _____

Name you prefer to be called: _____ D.O.B. _____ Age: _____

Mailing Address: _____

_____

Physical Address, if different than above: _____

_____

How did you learn of this practice? _____

Occupational Information

Employer/Business: _____

Occupation: _____ City where you work: _____

How long have you been with this employer/business? _____

IF STUDENT, School and Grade: _____

Highest level of education completed and name of the institution: _____

_____

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Contact Information

Contact Preferences

Voice	**Preferred?**
Cell: (_____)_____	☐
Work: (_____)_____	☐
Home: (_____)_____	☐

Email: _____

Contact Consent

May I contact you via:

Email	☐ Yes	☐ No
SMS Text	☐ Yes	☐ No

May I leave a voice message at:

Cell	☐ Yes	☐ No
Work	☐ Yes	☐ No
Home	☐ Yes	☐ No

Should I need to mail something to you, may I do so to your mailing address? (Only my name & return address appears on envelopes.) ☐ Yes ☐ No

If you prefer an Alternate Address, please list it here: _____

_____

Emergency Contact – REQUIRED

NOTE: If you are in couples counseling, please list a contact other than your spouse/partner.

Name of Contact: _____ Relationship: _____

Phone: _____ Alt. Phone: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

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Mental Health History

Are you currently seeing, or have you ever seen, a psychiatrist, psychologist, or counselor? Please give their name, approximate months seen, and primary purpose of visits.

Have you ever attempted suicide? ☐ Yes ☐ No

Have you ever had suicidal thoughts? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No How many drinks per DAY/WK of alcohol? _____

Drink of choice? _____

Do you use medication/substances (i.e., prescribed, OTC, or recreational drugs) or dietary supplements? (Please list name, purpose, and frequency)

Have you ever been hospitalized due to mental illness? (If so, list dates and name of hospital and physician.)

What is the primary reason that brings you here today? Include desired outcome or goals you have for therapy.

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Payment Information

All payments are due in full at time of service. Insurance Superbills are provided at your request for you to file for any out-of-network benefits you may have for behavioral health counseling.

If meeting in-person: Please present your card to be manually swiped and electronically stored at the first session.

If using Telehealth: Please verbally tell your therapist your charge card information.

How do you plan to handle payment for counseling services?

☐ Check* ☐ Cash ☐ Credit/Debit Card ☐ FSA ☐ HSA ☐ Zelle ☐ Apple Pay

* Make checks payable to "Dr. Gary Kindley".

Payor's Authorization and Consent

Client Name: _____

I authorize Dr. Gary Kindley, Pastoral Psychotherapist, to store my charge card information on file electronically and to charge therapy session fees, material fees, and cancellation fees electronically and without my signature for each charge. I understand that this authorization is valid until canceled in writing. I understand that this information is secured using financial industry encryption and I agree to hold Dr. Kindley harmless should my personal/financial information be compromised.

I understand that upon termination of therapy services, Dr. Kindley may charge any outstanding session fees for non-cancellation of appointment 48 hours prior to the scheduled session, as well as any materials (e.g., books, DVDs, etc.) that I have borrowed and not returned within one week of termination. I understand that if a charge back fee or a retrieval fee is incurred, I am responsible for these fees.

I agree that if I have any concerns or questions regarding charges to my account, I will contact Dr. Kindley for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Dr. Kindley and those attempts have failed.

Further, if I am assuming financial responsibility for the client listed above, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions. I understand that all therapy sessions will be charged per this form if a session is not cancelled at least 48 hours in advance. In case of illness or urgent reason to cancel, I will call or text 214-499-8181. Email is NOT an acceptable means of cancellation notice.

I understand and agree to the terms of this payment policy.

Payor Signature: _____

Print Name: _____

Date: _____