PSYCHOLOGICAL SERVICES CENTER
G-382 Kinard Hall
University, MS 38677

C O N F I D E N T I A L
APPLICATION

Name: ______________________________ **Date:** ______________ **CLIENT #________**
(Last) (First) (Middle)

Address: ____
(Street) (Apt,) (City) (State) (Zip)

- Can we mail you at this address? (Circle one) **Yes** **No**

Home Phone: ( )__________ Work Phone ( )__________ Cell Phone ( )__________

Email Address:______________________________

It is okay to call me: (Circle all that apply) **Home Work Cell** It is okay to leave a message for me? **Home Work Cell Email**

Birth date: __________ Age: ________ Gender: ______ Sexual Orientation: ________

Social Security #: ______________ Religion: ____________ Ethnicity: ____________

Occupation: ______________ Employer:______________________

Relationship Status: ______Single ______In a Relationship ______Married ______Separated ______Divorced ______Widowed

Education: Highest grade ______________________________

How did you find out about us? (Please check one) ☐UM Counseling Center & Name: ______________

☐Doctor & Name: ____________ ☐Prof's Name:____________ ☐Friend/Family: ____________

☐ P.S.C. Website ☐Yellowpages.com ☐Phone Book ☐Previous client ☐ Other: ______________

Brief description of your reasons for therapy: ______________________________

____

Family Information

Spouse's/Partner's Name: ______________

Birth date: ____________Age: ____Spouse's/Partner's Occupation______________________

Spouse's/Partner's Education: Highest Grade or Degree completed ______________________

Number of Children or Dependents: __________

Children:	Name	Age	Male or Female	Living with you?

**** Person to contact in case of an emergency:**

____
(Name) (Address) (Phone) (Relationship to You)

Father's Name: ______________________________
Birth date: ________________ Age: ________
Education: Highest Grade or Degree completed ______________________

Mother's Name: ______________________________
Birth date: ________________ Age: ________
Education: Highest Grade or Degree completed ____________

Payment Information

Are you a student, faculty, staff or a dependant of**,** at the University of Mississippi? Yes____No_____
Please answer: Total household monthly net income: ____________
Number of people other than yourself relying on this income: __________

The Psychological Services Center provides therapy to you and your family at an affordable cost based on monthly income, dependents, and hardship. If you live in the community and are not a dependent of a UM student, we determine the fee for therapy sessions based on your family's monthly income and the number of dependents in your family. We understand that there are a few cases in which a client is unable to make payment. If you feel that you are unable to afford the quoted fee, please speak with your therapist or the Clinic Manager in order to make arrangements.
Full payment is due at the time of services unless other arrangements have been previously made. We accept **cash**, **checks or credit cards**. Although we do not make insurance claims directly, we can provide you with the receipt to send with the insurance claim.

I understand and agree to the conditions and terms of payment at the Psychological Services Center.

Date: ____________ Signature: ______________________

Sign on back →

INFORMATION ABOUT OBSERVATION AND RECORDING

CONSENT TO OBSERVATION BY PSYCHOLOGICAL SERVICES CENTER STAFF

Observation of therapy session may be required by the supervising psychologist and will be used solely for the purpose of training and supervision. Any information obtained through the use of this teaching procedure will be held in the strictest of confidence by the Center's staff.

You have the right to prevent observation of any or all portions of a therapy session without prior written approval.

I, the undersigned, authorize the staff at the Psychological Services Center to observe any of all services I receive at the Center.

► Signed: ____ Date: ______________________

The above name is a minor, and I as his/her parent or guardian, have read to the terms of Psychological Services Center's Psychotherapist-Patient Services Agreement.

Signed: ____ Relationship: ____________________

CONSENT TO ELECTRONIC RECORDING

The recording of therapy sessions may be required by the supervising psychologist and will be used solely for the purpose of training and supervision. Any information obtained through the use of electronic recording will be held in the strictest of confidence by the Center's staff. At the termination of services at the Center, all electronically recorded records will be erased, unless I authorize by written permission that a permanent copy of the recording may be kept by the center.

You have the right to prevent observation of any or all portions of a therapy session without prior written approval.

I, the undersigned, authorize visiting scholars and professionals to observe any or all services I receive at the Center.

► Signed: ____ Date: ______________________

The above name is a minor, and I as his/her parent or guardian, have read to the terms of Psychological Services Center's Psychotherapist-Patient Services Agreement.

Signed: ____ Relationship: ____________________

I, the undersigned, am an authorized representative of the Psychological Services Center and have witnessed the above signatures on the date they were provided.

Signed: ____ Date: ______________________