NEW CLIENT INFORMATION/CONSENT FORM

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Welcome to my practice. Please take a few minutes to fill out the following form. This information will enable me to better meet your needs. Thank you for your time.

Client Name: _____ **Today's Date** _____
(To be completed by the Parent/Guardian if patient is younger than 18 years)

Date of Birth _____ **Age** _____

Address _____
Street address City State Zip
Email Address_____ ☐ I do not wish to receive emails

Phone Number(s): Home _____ Work _____ Cell _____

May we call you **...at home?** ☐ yes ☐ no **...at work?** ☐ yes ☐ no

Current Relational Status: ☐ Single ☐ Married - Date _____ ☐ Co-habitating-Date_____

☐ Separated - Date _____ ☐ Widowed-Date_____

Prior Marriages: **Please list all prior marriages, including the date of marriage and date of divorce:**_____

_____

Please list all of your children:

Name _____ **Age**_____ **In home? ___Y ___N**

Name _____ **Age**_____ **In home? ___Y ___N**

Name _____ **Age**_____ **In home? ___Y ___N**

Name _____ **Age**_____ **In home? ___Y ___N**

Employer/School_____**Occupation**_____

Referred by: _____

Internet:

Yelp_____

Google_____

Other_____ **(please specify)**

It is our policy to acknowledge all referrals with a thank you card. If you <u>do</u> <u>not</u> want your referrer to be contacted, please check here.

New Patient Information/Consent Form

Person to be contacted in case of an emergency

Name _____ Relationship _____

Home phone:_____ Work phone: _____

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Presenting Problem(s):
Please describe your reasons for seeking counseling (include date/month the problem started):

_____

_____

_____

_____

_____

_____

_____

_____

Please list any serious medical conditions that you are or have been treated for:

_____

_____

_____

_____

_____

_____

When did you last have a physical examination?

_____

Who did you see? _____ _____
Name Phone Number

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PLEASE INDICATE ANY AREAS OF CONCERN TO YOU AT THIS TIME:

Marriage/Relationship ____ □

Family _____ □

Job/School performance _____□

Friendships _____□

Hobbies _____□

Financial Situation _____□

Physical Health _____□

Anxiety level/Nerves _____□

Depression _____□

Suicidal Ideation _____□

Mood _____□

Eating Patterns _____□

Sleeping Patterns _____□

Sexual functioning _____□

Ability to concentrate _____□

Ability to control your temper_____□

Please list any medications that you are currently taking:_____

_____

_____

Please describe any current or past problems with substance abuse:

_____

_____

_____

Please give a brief description of any previous therapy experiences you have had including substance abuse treatment._____

_____

_____

_____.

New Patient Information/Consent Form

Please add any information that you would like me to know that is relevant to your treatment.

_____

_____

_____

_____

_____.

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Confidentiality
All information between counselor and patient is held strictly confidential unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a physical danger to others.
4. Child/elder abuse/neglect is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

Electronic Communication: Please be aware that I cannot guarantee complete security with regard to electronic communications. I recommend that email be used only for informational reasons such as requesting information or changing an appointment time. Personal information should be communicated by phone, text or at the time of the appointment.

Clients whose costs are covered by insurance should be aware that coverage always requires a diagnosis. Some insurance companies require even greater information in order to complete treatment reports. Any treatment reports will be discussed with you.

It is assumed that by requesting the completion of an insurance form you are granting permission to fill out the necessary information concerning diagnosis and treatment. Questions regarding your insurance company's policies on confidentiality should be taken up with the company directly.

Financial Terms
The hourly therapy fee is $185. unless other arrangements have been made. Full payment is due at each session. While some insurances may cover a portion of the fee, payment is the responsibility of the client. Assistance with the billing of insurance carriers will be provided at no fee by the therapist. Check, cash or most credit cards are accepted.

Canceled/Missed Appointments
A scheduled appointment means that time is reserved only for you. **If an appointment is missed or canceled with less than 24 hours notice, the client will be billed according to the scheduled fee.** Missed appointments are not covered by insurance and are the responsibility of the client.

Sessions are 50 minutes in length unless otherwise scheduled.

Consent for Treatment
I authorize and request that Sally LeBoy, MS, MFT, provide psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

_____ _____
Signature of Client (or parent/guardian) Date

_____ _____
Signature of Therapist Date