

Anne Marie Cook, LCSW

Michele V. Ward, MS, LPC

New Client Information Sheet

CLIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: ____/____/____

Name of Parent/Legal Guardian (if minor): _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Current School attending (if minor): _____ Grade _____

Social Security #: ____/____/____ Email Address: _____

Sex: Female Male Marital Status: Single Married Other

If client is a Minor: Custody (or Guardianship) Agreement in Place? Yes No N/A (Circle one)

RESPONSIBLE PARTY (IF OTHER THAN CLIENT):

Name: _____ Date of Birth: ____/____/____

Employer: _____ Occupation: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: ____/____/____ Email Address: _____

Sex: Female Male Marital Status: Single Married Other

Reason for referral: _____ Previous Therapy/Counseling: _____

Family Physician: _____ Date of last Physical: _____

Overall Health: _____ Chronic Health Conditions: _____

Current Medications: _____

Mother's Name: _____ Cell: _____

Father's Name: _____ Cell: _____

List names of immediate family members or others living in the home: _____

FEE SCHEDULE

The undersigned understands and agrees to accept full financial responsibility for all charges. The therapist, if out of network, will collect payment from the client, but will provide all necessary information for client to submit insurance. Checks that are returned for insufficient funds will be billed to the credit card on file along with a \$35.00 bank fee. Should the account be referred to an attorney or collection agency for collection, the undersigned client and/or client's guarantor will be responsible for actual attorney fees and/or collection expenses.

The fee for your initial session is \$ 150.00. The fee for each talk therapy session thereafter is \$130. The fee for each neurofeedback, biofeedback or other therapy session is \$110.

If paying by credit card, all charges will be processed at the end of each week and receipts mailed to the address on file, unless otherwise requested. Receipts for services paid by check or cash can also be mailed if requested.

Additional time may be charged accordingly. Phone consultations, forms, and letters lasting in excess of 15 minutes or more may be charged accordingly.

Expires 12/31/2017

I have read and agree to the payment policy and fee schedule.

Signature of Client

Date

Signature of Guarantor/Guardian (if a minor)

Date

Signature of Therapist

Date

Anne Marie Cook, LCSW

Michele V. Ward, MS, LPC

Statement of Understanding

This information is provided to you to help you better utilize psychotherapy services.

PRIVACY/CONFIDENTIALITY

If you need any of your information to be released your written permission is required by law. In addition, state law requires that any mental health professional is responsible for reporting to appropriate parties' instances when a person is a danger to him or herself, to others, or when a child or vulnerable adult is involved in abuse and/or neglect.

RIGHTS AND RESPONSIBILITIES

You have the right to refuse treatment. Even though your therapist may make certain recommendations, you may choose not to follow the therapist's advice. Should you refuse treatment, you will be apprised of consequences that may result from your refusal. Alternatives may be available, You have the right to know the assessment of your problem, the recommended treatment and any resources available to support you.

Along with these rights go certain responsibilities:

To be honest, open and willing to share your concerns with your therapist. To ask question when you do not understand or need clarification. To follow the treatment plan agreed upon. To discuss any reservations you may have about your treatment goals. To keep appointments or to call with in 24 hours prior to your appointment, otherwise you will be charged for that session.

FEEES

Please be sure that you have read and understand the Fee Statement Policy, you assume financial responsibility for such services.

We are here to support and assist you to the best of our ability.

Client or Guardian Signature

Date

Anne Marie Cook, LCSW

Michele V. Ward, MS, LPC

NOTICE OF PRIVACY PRACTICES

This Notice describes how psychological and health information about you may be used and disclosed and how you can get access to this information.

I have read and received (if requested) and understand the privacy practices information. I understand that my signature on this form acknowledges receipt of these documents and acceptance of the conditions of the privacy policies of the following providers:

- **Michele V. Ward, MS, LPC**
- **Anne Marie Cook, LCSW**

Client

Date

Parent or Guardian

Date

Anne Marie Cook, LCSW

Michele V. Ward, MS, LPC

CANCELLATION AND NO SHOW POLICY

Cancellations are required to be made 24 hours in advance. If a cancellation is made without giving a 24 hour notice, the client and/or guarantor will be charged the full fee of the session. It is the responsibility of the client to pay the full fee of the session for any missed appointment or late cancellations. Cancellations must be made Monday through Friday during normal business hours. Cancellations made after working hours on Friday, Saturday and/or Sunday are not to be considered to be a 24 hour notice for the following Monday. A credit card must be kept on file for charges associated with cancellations or “no shows”. A statement will be sent to you informing you of the amount and date charges were applied.

PAST DUE BALANCES

Account balances more than thirty days past due or any returned checks will be charged to the client’s credit card on file. Any bank fees associated with a returned check will also be charged to the credit card on file. A credit card must be kept on file for charges associated with any therapy services. A statement will be sent to you informing you of the amount and the date charges were applied.

CREDIT CARD INFORMATION

Type of Credit Card Visa MasterCard

Name as it appears on the card: _____

Credit Card #: _____

Exp. Date ____/____/____ CCV Code: _____ Billing Zip: _____

I would like my credit card to be charged for all future office visits. Please charge my payment and/or deductible (if applicable) to the above card.

Yes No

By signing below, I acknowledge receipt of these policies and agree to abide by them.

Client Name (Please print)

Therapist

Client or Guardian’s Signature

Date