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

New Client Information Sheet

Date: ________________

CLIENT INFORMATION

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)

INSURED/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 ○

Authorization # (if applicable): _________________________ How many sessions: ____________________

Reason for referral: ________________________________ Who referred you? ________________________

Previous Therapy/Counseling: ____

Family Physician: _____________________________ Date of last Physical: ___________________________

Overall Health: _________________ Chronic Health Conditions: ___________________________________

Current Medications: ____

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

____

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

Fee Statement Policy

The undersigned understands and agrees to accept full financial responsibility for all charges and to pay the portion not expected to be covered by insurance. If remittance from the insurance company is not received, the therapist reserves the right to collect payment from the client and/or client's guarantor. Should the account be referred to an attorney or collection agency for collection, the undersigned client or client's guarantor will be responsible for actual attorney fees and/or collection expenses.

The fee for your initial session is $ __________________. The fee for each session thereafter is $______________. Your co-payment is $ ___________ or deductible (if applicable) is $ __________ thereafter your co-payment is $ ____________.

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

You have ____________ EAP (Employee Assistance Program) sessions available to you at no co-payment. Further sessions may be available through your medical benefits with co-payments and/or fees.

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 are utilizing your medical insurance, please be aware that an insurance company and/or managed care company always requires that a mental health diagnosis be made and specific symptoms and information be shared in order for you to receive your benefits. This information is typically entered in a computer network in another part of the country. Your written permission is required by law for this information to be released. 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 you 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.

FEES

Please be sure that you have read and understand the Fee Statement Policy, and that while medical benefits may defray some of the costs of the services, you assume financial responsibility for such services.

We are here to support and assist you to the best of our ability. I have read and received a copy (if requested) of this information.

______________________________	______________
Client 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:

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

____________________________   ________________
Client Signature   Date

____________________________   ________________
Parent or Guardian Signature   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. <u>It is the responsibility of the client to pay the full fee of $130.00 for any missed appointment or late cancellations</u>. 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 48 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 sixty (60) days past due will be charged to the client's credit card. Past due balances for neurofeedback services are covered under a separate policy noted in that agreement. A credit card must be kept on file for charges associated with past due balances. 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 _____/______

Security Code: ___________________ Billing Zip: ______________________

I would like my credit card to be charged for all future office visits. Please charge my co-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**