# CLIENT INFORMATION SHEET

Please complete all items. Information is held as strictly confidential.

**Client Name**______________________________________________Birthdate_____________Age_____ M___ F___

If client is a minor, Parent's name______________________________Birthdate_____________ Age_____ M___ F___

Address_______________________________________________City_____________________Zip______________

Home Phone_____________________Cell Phone_____________________Wk. Phone_________________________

Email Address: ________________________________________________________________________________

Single_____ Married______ Separated______ Co-Habitating______ Divorced______ Widowed_____ Engaged_____

Employer ________________________________________________________________ No. Years______________

Address_______________________________________________City_____________________Zip_______________

Occupation____________________________Education___________________________Religion_______________

Driver's License #________________________________Social Security #___________________________________

**Spouse Name** ______________________________________________ Birthdate ___________Age_____ M ___ F___

Address_______________________________________________City_____________________Zip_______________

Home Phone_____________________Cell Phone______________________Wk. Phone_______________________

Employer________________________________________________________________ No. Years_____________

Address_______________________________________________City_____________________Zip_______________

Occupation____________________________Education___________________________Religion_______________

Driver's License #________________________________Social Security #___________________________________

**Emergency Contact Name**______________________________________________________________________

Relationship______________________________________________________________________________________

Address________________________________________City________________Zip_________Ph________________

Employer Name_____________________________________________________Ph__________________________

**Other Children Living at Home:**

Name______________________________________________________Birthdate____________ Age_________M___F___

Name______________________________________________________Birthdate____________ Age_________M___F___

Name______________________________________________________Birthdate____________Age_______ M___F___

Name______________________________________________________Birthdate____________Age_______ M___F___

# CLIENT INFORMATION SHEET



**Previous counseling, psychiatric treatment or testing:**

Agency_____________________________________________________________________

Therapist/Dr. Name__________________________________________________________

Date_______________________________________________________________________

**Patient referred to this office by:**

___________________________________________________________________________

**Physician Name:** _________________________________________________________

Address____________________________________________________________________

Phone______________________________________________________________________

**Military Background**

Dates of Service ________________MOS ________________ Rank _____________________ Deployment

Yes ___ No ___How many times Deployed ______ Where? ___________________

**IF CLIENT IS A CHILD AND PARENTS ARE SEPARATED OR DIVORCED, PLEASE COMPLETE THE FOLLOWING:**

Name and address of other parent (if not living in the same home):

___________________________________________________________________________

Name

___________________________________________________________________________Address

City Zip Phone

Employer of other parent: ___________________________________________________

___________________________________________________________________________

Address City Zip Phone

Please indicate the legal stipulations of custody:

___________________________________________________________________________

**PLEASE STATE REASON YOU ARE SEEKING COUNSELING:**

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**Please read the information below and sign your name in the spaces provided. Should you have any questions, please feel free to discuss any of these issues with the receptionist or your therapist before signing.**

**Client's Rights and Responsibilities:**

As a client, you have certain rights:

- You have the right to know our assessment of the problem, the recommended treatment plan, and resources available to help improve this problem.
- You have the right to refuse treatment. Even though your counselor may strongly suggest you seek help, you may choose to not follow the counselor's advice. Should you choose to refuse treatment, you will be advised of the consequences that may result from your refusal. Alternative forms of treatment or help may be available.

Along with these rights go certain responsibilities. These are:

- To be honest, open and willing to share your concerns with your counselor
- To ask questions when you do not understand or need clarification
- To discuss any reservations you have about your treatment plan with your counselor
- To follow the agreed-upon treatment plan
- To report changes or unexpected events as related to your problem with your counselor

**Fees:** Standard fees are $150.00 for each individual session (45-50 minutes). In cases of financial difficulty, you may qualify for a courtesy discount. **Please feel free to discuss this arrangement with your therapist**.

**Cancellations and Missed Appointments:** As the time reserved for your appointment is your time, please give **48-hour notification** if it is necessary to cancel an appointment. There will be a **one full session charge** for any missed or late cancelled appointment.

**Payment:** Payment is due at the time of your appointment and it is requested that you keep up with your co-payment on a weekly basis or make arrangements with your therapist. You are responsible for any charges incurred by your bank for returned checks.

**Confidentiality:** Information shared with your therapist is confidential unless you have signed a release.
According to the law, the following may be shared without a signed consent: observed or suspected **child abuse, elder abuse,** prevention of **bodily harm** to yourself or to another person, any information **subpoenaed by court** or otherwise necessary to the administration of justice, filing an **insurance claim, breach of contract** (small claims court), if a client is a **minor,** or the client experiences an **emergency** requiring information from the client's record to be given to another health care provider or for other reasons which can be explained by the therapist. Further as we are a group practice, support staff may be aware of limited clinical information to aid in therapist's functioning. We, as a staff will maintain your confidentiality.

**Consent for Treatment:** I have completely read this form and certify that I am the client, or the client's parent or guardian. I authorize my therapist to administer and perform treatment and diagnostic procedures that may now or during the course of treatment be deemed advisable or necessary.

______________________________________________________________

Signature of client (Parent or Guardian if under 18 years of age) Date

**Statement of Financial Responsibility:** I understand that even though I may have insurance coverage, I am responsible for payment. I agree to the terms of this payment policy.

______________________________________________________________

Signature of client (Parent or Guardian if under 18 years of age) Date

**Authorization to Release Information:** A treating doctor or therapist/counselor referred me and I have no objection to having my therapist communicate with the referring professional regarding my care.

______________________________________________________________

Signature of Responsible Party