Stephan P. Michener, LCSW
Individual Counseling

100 CrossKeys Office Park
Fairport, NY 14450
(585)383-4478

Client Information **Today's Date**__________________

Client Name______________________________________ **DOB**_________________________

Street Address____________________________________ **Age** __________________________

Town___________________________ **ZIP**_____________

Home Phone _____________________________ **Work Phone** ______________________________

Cell Phone _______________________________**Email** _____________________________________

Where do you prefer I contact you if I need to? ____

Insurance _______________________________ **Subscriber**_________________________________

Insurance number o subscriber____

Subscriber DOB __________________

Employer or school you attend____

Level of Education ____

Please circle **Never married** **Married** **Separated** **Divorced**

Emergency contact (name and phone number) ____

Primary Care Physician ____

Please list family members and others <u>who live with you</u>

____ ____________
Name **relationship** **Age**

____ ____________
Name **relationship** **Age**

____ ____________
Name **relationship** **Age**

____ ____________
Name **relationship** **Age**

Previous counseling? Yes No Name of counselor or program_____________________________
I will not contact them without your permission!

<u>Over please</u>

<u>Please answer the following questions as fully as possible</u>

1. Place a check mark next to each item that you experience.

___ sleep difficulty	___ loss of appetite	___ increased appetite
___ crying spells	___ sad feelings	___ irritable mood
___ depressed mood	___ trouble concentrating	___ desire to be alone
___ anxious feelings	___ angry outbursts	___ loss of interest in activities
___ decreased sexual desire	___ thoughts of death	___ suicidal thoughts
___ intense panic	___ extreme apathy	___ trouble waking up
___ low energy	___ low self esteem	___ hopelessness
___ worthlessness	___ Guilt	___ isolation
___ Loss	___ Stress	___ Headaches
___ Loneliness	___ Heart pounding/racing	___ Chest Pain
___ Trembling/shaking	___ Chills/ Hot flashes	___ Sweating
___ Tingling/numbness	___ Fear of dying	___ Nausea
___ Fear of going crazy	___ Phobias/fears	___ Nightmares
___ Obsessions	___ Compulsive behavior	___ racing thoughts
___ Intrusive thoughts	___ Relationship problems	___ Sexual problems
___ Physical abuse	___ Sexual abuse	___ Spousal abuse
___ Blackouts	___ Excessive drinking	___ drug abuse
___ Prescription abuse	___ Over spending/gambling	

2. Allergies ____

3. When was your last visit to you doctor?____

4. Please list any medications you are taking ______________________________________

____

5. Please list any medical conditions you are experiencing ___________________________

____

6. Use of Alcohol/Drugs ____

7. Use of Cigarettes/Caffeine ____

8. In your family is there a history of; alcoholism/substance abuse ______, mental illness _____ ,

Suicide/attempts _____

9. What is happening in your life which resulted in this appointment? ____________________

____

10. What would you like to see accomplished in therapy? ______________________________

____

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name ____

DOB: _________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Stephan Michener's Notice of Privacy Practices.

____
Signature of Patient/Client Date

____
Signature of Parent, Guardian or Personal Representative* Date
*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt____________

____
Stephan P. Michener, LCSW Date

Stephan P. Michener, LCSW
100 CrossKeys Office Park, Suite 115
Fairport, NY 14450
(585) 383-4478

INSURANCE AND PHYSICIAN RELEASE OF INFORMATION

Insurance companies require counseling providers to be able to communicate with PCP's when necessary. This information includes the date of the first appointment, a brief overview of the presenting concern(s), a "working" diagnosis, and a treatment plan. In order to comply with this requirement, I must have your written consent to provide information to your doctor if necessary.

I ____ give Stephan P. Michener, LCSW
(print name)

permission to provide the above information to my primary care physician

______________________________________.
(Doctor's name)

____________________________________ ________________________________
Client Signature Date Stephan P. Michener, LCSW

Permission to submit claims

I, ____,
Print Name
give permission to Stephan P. Michener, LCSW to submit claims to my insurance provider

____, for rendered counseling services.
I understand that information disclosed will remain confidential and is for billing purposes only.

"I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to Stephan P. Michener, LCSW."
"I authorize payment of medical benefits to Stephan P. Michener, LCSW"

____ ____________________
Signature Date

____ ____________________
Witness Date

Stephan P. Michener, LCSW
(585) 383-4478
100 CrossKeys Office Park
Fairport, NY 14450

Policies on Payment, Late Cancellations and No Shows (2023)
Please read carefully!

- I accept cash, checks, debit and credit cards. **Payment is due at the time of each appointment.**
- At the time of the first appointment I require that you provide me either debit or credit card information and authorization to bill your card should you cancel late (less than 24 hrs. notice) or fail to show for an appointment. Even if you intend to pay for appointments by cash or check I require this information and will **only** bill your card in the event of a late cancel or a no show or if your insurance fails to reimburse due to your insurance policy not covering counseling. Charges on your statement will appear as *Stephan Michener, LCSW*.
- **If your insurance fails to reimburse their portion of the co-pay then you are responsible. Although I accept all major insurances, some plans vary in what they allow for counseling coverage. Due to the constant changes in the multitude of various insurances and their sub-plans I expect you to know your specific plan's policies. Please be sure that counseling is covered by your plan. In the event that your insurance fails to pay I will bill your credit/debit card for the balance.**
- There is a $45 charge for returned checks
- If I, Stephan Michener cancel an appointment with less than 24 hours notice or fail to show for the appointment, there will be no charge to you for the next appointment.
- **24 hours advance notice** is required for all cancellations. For Monday appointments the notice must be received by the previous Friday at 4pm. Failure to provide at least 24 hours notice or not showing for an appointment will result in a charge for the **full** cost of the session. **The full cost of a session is $110 in 2023**. Your insurance will not reimburse for late cancellations or no shows, and you will be solely responsible. **This policy is strictly enforced**!
- In the event that there is an unpaid balance that is more than 30 days past due (including for late cancellations and no shows) it will be turned over to FMS Financial Solutions collections agency.

I have read and agree to all of the above. My credit/debit card information is as follows, and I authorize payments for cancellations with less than 24 hours notice, missed appointments, and denied insurance claims due to lack of coverage.

MC VISA AMEX DISCOVER (Circle One)

______________________________ ______________
Name on Card Zip Code

______________________________ ________ ______________
Card Number Security Code Expiration Date

______________________________ ______________________________
Client/Card Holder Signature Stephan P. Michener, LCSW Date