Elizabeth J. Childs, MS, LMHC, LMT, SEP

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Name_____ Age _____ Birth date _____

Phone: home ( )_____ work ( )_____ cell ( )_____

Address _____ City _____ Zip _____

Medical Information

Are you currently under a physician's care? No ____ Yes ___ Name _____

Currently using medication? Yes ____No ___ Please list medications: _____

_____

Have you seen a therapist in the past? Yes ____ No ____

When _____For _____

Who referred you to Elizabeth Childs?
_____

Emergency Contact

Emergency contact person's name _____

Contact's phone: home:_____ work:_____ cell:_____

_____

Please turn the page, read and sign ===>

GUIDELINES THAT INFORM OUR WORK TOGETHER

Confidentiality: What you talk about in therapy is confidential and protected by law. Your right to privacy is respected, and it is important to have a safe environment to work in. There are three times when the law requires me to disclose confidential information without your written permission:

- If there is a reasonable suspicion of child or elder abuse.
- If there is a reasonable suspicion that you present a danger of harming someone else.
- If it appears likely that you will harm yourself.

Cancellations: If you need to cancel an appointment I ask that you notify me by telephone at least ***48 hours*** in advance of your appointment***.*** I am willing to try and reschedule last minute cancellations within the same week, or two hours in the next week, at no additional charge. If another appointment cannot be made payment for the missed hour is expected. You would be responsible for the full amount usually billed to insurance, or a third party.

Payment:

- Payment is expected at each session unless we make other arrangements.
- If you plan to use your health insurance to help pay for counseling, it is your responsibility to know what is required for submitting claims. We can submit claims with me as an out of network provider. I am happy to provide assistance in filling out forms and working with the insurance company.

Please read and initial the following statements:

_____ For insurance billing, I authorize the release of the minimum medical or other information necessary to process the claim.

_____ I authorize payment to Elizabeth Childs, MS, LMHC, of medical benefits for mental health services provided by Elizabeth Childs, MS, LMHC.

_____ I agree to the fee of $ _____ per session.

_____ I have read the information on this page and agree to the stated conditions.

Signature _____ Date _____