Client Confidential Information

Name:

Address:

Phone #: (H) (W) (Cell)

Email:

Occupation: Place of Work or School Attended:

Date of Birth (D.O.B.): Age: Marital Status:

Spouse (if applicable): Name: Age: D.O.B: Occupation:

Children (if applicable):
Name: Age: | Name: Age: | Name: Age:

Parents (if client is a minor):

Parent 1: Name: D.O.B.: Age:

Address:

Phone #: (H) (W) (Cell)

Email:

Parent 2: Name: D.O.B.: Age:

Address:

Phone #: (H) (W) (Cell)

Email:

In your family was there any history of: ___Alcoholism? ___Substance Abuse? ___Mental Illness?
___ Prolonged Physical Illness? What Kind?

Current Medications:

Significant Medical Problems:

Have you ever had psychiatric care and/or counseling? ___Yes ___No
If yes, give: Name of clinician: Dates:

Have you ever been hospitalized for psychiatric disorders, eating disorders, substance abuse or alcoholism?
___Yes ___No Details:

Referral Source (name and phone number if available):

INSURANCE INFORMATION:

Primary Insurance Holder's Name:

Employed by:

Employer's Address & Phone #:

Name of Insurance Company: Name & address (if different) of Insured:

Member #: Group #: D.O.B: SS#:

Insurance Co. Billing Address & Phone#:

Secondary Insurance Holder's Name:

Employed by:

Employer's Address & Phone #:

Name of Insurance Company: Name & address (if different) of Insured:

Member #: Group #: D.O.B: SS#:

Insurance Co. Billing Address & Phone#:

I ______________________(person responsible for payment) understand and agree to pay Maren Handler Siegel, LICSW the amount of $_______ for my _______ minute session. My insurance is responsible for _____% which equals $______, and I am responsible for _____% which equals $______. If Maren Handler Siegel, LICSW is not directly covered under my insurance plan, I am responsible for the entire amount, and it is my responsibility to seek reimbursement.
I understand that I am responsible for payment for consultations not cancelled 24 hours in advance. I understand that if I choose to use a credit card to pay my balance, there may be an additional fee attached. Payment for services is rendered at the conclusion of the consultation unless other arrangements have been made. I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment.

Client's Signature ________________________________ Date: __________________

Spouse's Signature ________________________________ Date: __________________
(if applicable)

Parent/Guardian
Signature ________________________________ Date: __________________
(if applicable)

CLIENT'S BILL OF RIGHTS

You, the client, have the right to:

- Receive respectful treatment that will be helpful to you.
- Receive a particular type of treatment or end treatment without obligation or harassment
- A safe environment, free from sexual, physical, and emotional abuse
- Report unethical and illegal behavior by a therapist
- Ask questions about your therapy
- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations
- Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in case of vacation and emergencies), and cancellation policies before beginning therapy.
- Refuse electronic recording.
- Refuse electronic communications (with the understanding that this form of communication is not for therapy purposes. This form of communication is used solely for logistics: i.e. scheduling, cancellations, notification of running late. This form of communication included emails as well as cell phone texts).
- Refuse to answer any questions or disclose any information you choose not to reveal.
- Understand that I can request a copy of these rights at any time.

I have read and understand my rights as a client of Maren Handler Siegel, LICSW:

Signature (parent/guardian if appropriate):

____Date______________

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

PARAMETERS OF ELECTRONIC COMMUNICATIONS

It is important to understand that both emails and cell phone texting are used for the sole purpose of logistics (i.e. scheduling, cancellations, notification of running late, etc.) and that therapy cannot be effectively provided in this form of communication. It is also important to know and understand that emails/texts are not always checked daily, and that if your communication is urgent or an emergency, a phone call is required.

Please note: In compliance with the Health Portability and Accountability Act "HIPAA" (rule 104-91), an electronic message is intended only for use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of your electronic message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, they are notified that any dissemination, distribution or copying of the communication is strictly prohibited. If they have received the electronic message in error, they are asked to please notify the sender immediately, and purge the electronic message immediately without making any copy or distribution. However, it is important to understand that confidentiality cannot be guaranteed when using electronic communication.

Consequently, the therapist cannot be held liable and accountable if he/she has only been contacted electronically.

Also, please be advised, Maren Handler Siegel, LICSW cannot 'Link In', become Facebook Friends, etc. with clients as a matter of confidentiality.

I agree to the above limits of confidentiality and the parameters of electronic communications, and understand their meanings and ramifications.

Signature (parent/guardian if appropriate):

____Date_______________