Rachel Moskowitz, M.S., LMHC
Client Information Form

Date: _____ Referred by:_____

Name:_____
First Middle Last

How do you prefer to be addressed (Name/Nickname):_____

Date of Birth: ____ /____ /_____ Age: _____ Email address:_____

Address:_____

City: _____ State: _____ Zip: _____

Occupation: _____Employer: _____

Ethnicity:_____Religion:_____

Gender: [ ] Male [ ] Female Last School Grade Completed: _____

Please circle: Single Married Partnered Separated Divorced Widowed

Cell Phone:_____can a message be left at this number?__yes __no

Work Phone:_____can a message be left at this number?__yes __no

Partner/Spouse's name:_____Partner/Spouse's employer:_____

Partner/Spouse's Phone number:_____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Phone: _____

INFORMED CONSENT FOR TREATMENT

Office of RACHEL MOSKOWITZ, M.S., LMHC

When finished, please sign below that you have read and understand the following:

Psychotherapy/counseling is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many methods that may be used to deal with your situation. This will not be like a medical doctor visit in that you will be an active participant in your counseling process, working both during and between your sessions.

Psychotherapy can have benefits and risks. Since therapy can involve discussing an unpleasant aspect of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience or in the outcome of this process. However, you will be involved in the setting of treatment goals, and these should be reviewed and assessed frequently during the course of treatment. **Please note that a clinical hour of therapy is 45-50 minutes.**

Your privacy and confidentiality of your participation in counseling and evaluation will be strictly maintained. This is not the case if you give your written permission for disclosure, or if law requires disclosure. These may include, but are not limited to the following situations: 1) assessed danger to self or others; 2) knowledge, or suspicion of, abuse of a child, elderly, or anyone who can not protect him/herself; 3) receipt of a court order requiring the release of information; 4) matters of national security and 5) a referral from worker's compensation.

Exception to the concept of absolute confidentiality may occur in the normal process of service delivery. This may involve, when appointments are confirmed; a supervisor or colleague consultation; a secretary typing a report; or an insurance company, managed care company, EAP, or other financial intermediary in the billing process. This may require disclosure of such data as diagnosis, treatment plan, historical data, drug and alcohol history, treatment history, presenting problem, and other information. **Your signature below provides permission to release such information.**

Please note that additional charges may be assessed for filling out disability and other such forms and for checks returned unpaid from your bank.

You will be financially responsible for all charges. It is your responsibility to obtain information from your insurance company regarding your benefits, out of pocket expenses and potential reimbursement. All fees are due at the time of service.

Signature_____ Date_____

Print name_____

Medical and Mental Health History Self-Report

Name:_____ Date of Birth:_____

Primary Care Provider:_____ Primary Care Phone #:_____

Psychiatrist:_____ Psychiatrist Phone #:_____

Please describe any **medical** issues you have been experiencing and believe I should know about:

_____

_____

Current Medications

Name of Medication	Dosage	For what reason?	How Long?	Side effects (if any)

Previous Mental Health Care (Such as: psychiatrist, psychologist, counselor, social worker, or psychological testing)

Provider Name	When?	Reason	Did you find it beneficial?

Please list any family members diagnosed with the following: anxiety, depression, bipolar disorder, schizophrenia, dementia, eating disorders, suicide or attempt, ADD/ADHD, alcohol/drug issues, OCD

What is the reason you are seeking help at this time?

How long have you had these problems or symptoms? How often do they occur?

Who lives with you at home?

Name of person	Relationship to you	Age	Occupation/School

Cancelled, Rescheduled, and Phone Session Appointments

Clients who cancel or reschedule appointments with less than 24 hours notice are responsible for the full fee for the time they have reserved. Exceptions may be made for extenuating circumstances at the sole discretion of the therapist.

In the event of a situation that requires a phone session exceeding more than 15 minutes, you will be charged the rate of a regular therapy session.

In order to avoid incurring unnecessary charges, please indicate a credit card that we can charge for missed or rescheduled appointments with less than 24 hour notice.

I, _____ approve my credit or debit card to be charged for my missed appointment or phone session per the terms outlined above.

Name listed on the card:_____

Card #:_____

Security number on card: _____

Expiration date:_____

Zip code:_____