Counseling ~ n ~ Healing
Inspirational Living

Kenneth G. Lent L.C.S.W.~R

CLIENT INFORMATION {Person being seen}

Name: ______________________________ Email. ____________________

Telephone: H. ________________________ Cell. ______________________

Address: ___________________________ Town. __________ Zip. ________

Date of birth/Age: __________ SS # ___________ Male. _____ Female. _____

Others living at home {list all names & D.O.B./ages} ____________________

____

Therapist {Office use only} ____

EMPLOYMENT INFORMATION

Employer: ____________________ Position: ______________ Years. _____

Education: {list High School/College/Trade School} ______________________

MEDICAL INFORMATION

Primary Doctor: _________________ Tel. ____________________________

List any significant health issues: _________________________________

____

List all medications you are presently taking and the dosage: _______________

BRIEF THERAPY HISTORY

Have you been in therapy before: Yes____ No ____ If yes, when/date.__________

Comments: {Positive/Negative Experience}________________________________

Name of therapist: ____

Brief description of issues worked on: ____________________________________

____

Religious Faith/Spiritual Beliefs: Yes____ No ____

Comments: {Is this an area you would care to explore?}______________________

Referred by: {Therapist/Doctor/Family/Friend/Website}______________________

INSURANCE INFORMATION: PERSON FINANCIALLY RESPONSIBLE

Name: ______________________ Relationship to Client: ____________________

Address: ____________________ Town. ________________ Zip. ______________

Tel: Work ______________ Home _____________ Cell ______________________

Social Security # _________________ Date of Birth _________________________

Employer: __________________________________ Tel. ____________________

Insurance Carrier: ________________________ Group/Member # ____________

FINANCIAL AGREEMENT

Your fee per session is $______ Your Insurance Co. will pay $______ per session

You have a deductible of $ ___________ which has/has not been met.

Your payment/copayment will be $ ____

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION.

FEES ARE RE-EVALUATED AND SUBJECT TO CHANGE EVERY 6 MONTHS.

If you have a DEDUCTIBLE, you will be responsible to pay $50.00 at time of each session. Your account will be adjusted once we receive the explanation of benefits from your Insurance carrier.

Counseling & Healing P.C. will make every effort to collect payment from your Insurance company. However, you are ultimately responsible for the amount due.

We ask that we maintain a copy of a CREDIT CARD that will only be charged if insurance become inactive or coverage is terminated to ensure rendered services are covered. As well, if your balance exceeds $100.00

Sessions are 45 minutes, unless otherwise agreed upon. Your time has been reserved for you. 24-hour notice is required for cancellation or you will be charged the regular session fee.

It is understood that charges will be added to your account for professional services rendered by your therapist {Ie. Telephone contacts over 15 mins., preparation of special forms, reports, documentation, court-time etc.} The fee for these services is $150.00 per hr. and is not covered by insurance.

EMERGENCIES

I check in with my answering service/voicemail several times a day. However, in the case of an emergency and you cannot reach me or your therapist, you are instructed to call or go directly to your nearest hospital emergency room.

STATEMENTS OF UNDERSTANDING

My therapist has reviewed this client-therapist agreement with me.

CLIENT ____ *Date* ______________

THERAPIST ______________________________________ *Date* ______________

PARENT/GUARDIAN IF MINOR _____________________ *Date* ______________

CONFIDENTIALITY STATEMENT

All information shared in session is confidential except in circumstances governed by the laws including the mandatory reporting of alleged harm to self or harm to others, particularly in the case of a child, handicapped person, or elder abuse.