Client Information Sheet—Adult Client

Client's Name: ______________________________ Client's Date of Birth: ______________

Client's Address: ______________________________ Social Security #: ______________

City/State: ______________________ Zip: ____________ Sex: Male Female

Client's Home Phone: ______________ OK to leave message? __________

Cell Phone: ______________ OK to leave message? __________

Work Phone: ______________ OK to leave message? __________

Email address: ______________________________ Email o.k.? __________

Emergency contact name: ______________________ Phone: ____________ Relationship?__________

How did you hear about my therapy services? ______________________________

Insurance Information: (Primary Insurance)

Name of Mental Health Insurance: ______________________ Insurance Phone #: ______________

Mental Health Claims Address: ______________________________________

Insured/Sponsor's Name: ______________________ Insured's Date of Birth: ______________

Insured/Sponsor's Address: ______________________________________

Insured/Sponsor's ID # (off of insurance card): ______________________________

Insured/Sponsor's Social Security #: ______________ ***Client's*** Relationship to Insured: Self Spouse Child

Insured's Employer Name: ______________________________________

Do you have other insurance? Yes No

Name of Mental Health Insurance: ______________________ Insurance Phone #: ______________

Mental Health Claims Address: ______________________________________

Insured/Sponsor's Name: ______________________ Insured's Date of Birth: ______________

Insured/Sponsor's Address: ______________________________________

Insured/Sponsor's ID # (off insurance card): ______________ ***Client's*** Relationship to Insured: Self Spouse Child

Insured/Sponsor's Soc Sec #: ______________ Insured's Employer Name: ______________________

SIGNATURE ON FILE

I attest that all of the information above is correct to the best of my knowledge. I authorize release of any medical or other information necessary to process claims to my insurance companies. I authorize payment of medical benefits to the physician or supplier for services described on insurance claims. I understand that verification of insurance benefits it not a guarantee of payment and that any unpaid balance is my responsibility.

______________________________ ______________

Signature Date

Adult Psychosocial History Information

Name: ______________________________________ Birthdate: ____/ _____/_______ Age: ______

Best number to reach you: ____________________________ Message? Y / N

Email address: ____ Email message o.k.? Y / N

Referred by: ____

Family Relationships:

Current Romantic Relationship Status: ____________________ If married, how long? _____________

If separated, how long? _______________ If living together, how long? _____________

Current Spouse/Partner's Name: ___________________________________

Former Spouse/Partner's Name: _____________________________ If divorced, how long? _________

Children: Name: ___________________ age: ______ Name: _____________________ age: _______

Name: __________________ age: ______ Name: _____________________ age: _______

Name: ___________________ age: ______ Name: _____________________ age: _______

List any specific concerns about your children: ____

____

____

List other family members with whom you have frequent contact (i.e. mother, father, siblings, etc.) _______

____

____

Work History:

Are you currently employed? Y / N If yes, place of employment: _____________________________

Position/Job Duties: ____

Is your work stressful? ____

Physical History:

Past Medical Concerns:____

____

Current Conditions: ____

____

Allergies: ____

List Current Medications and reasons (including psychotropic medications): _______________________

____

____

Do you have healthy eating and sleeping habits? ____

Please complete page 2

Habits (show frequency)

Tobacco: ________________ Alcohol: ________________ Illegal Drugs: ________________

Exercise: ________________ Other: ________________

Mental Health History

Please identify if you or anyone in your family has a history of the following:

	Please circle		If family member specify relationship:
Alcohol/Substance Abuse	self	family	
Anxiety	self	family	
Depression	self	family	
Domestic Violence	self	family	
Eating Disorder	self	family	
Obesity	self	family	
Obsessive Compulsive Disorder	self	family	
Schizophrenia	self	family	
Suicide attempts	self	family	

Have you been in counseling before? __________________________

When? __________________________ How long? ________________________________

Why terminated? ____

In what area(s) do you want help? ____

____

____

____

How has the above problem(s) impacted your daily life? (circle number in each area)

Minimally>>>>>>>>>>>>>>**Half the time**>>>>>>>>>>>>>>>**Totally**

Physically	1	2	3	4	5	6	7	8	9
Mentally	1	2	3	4	5	6	7	8	9
Socially	1	2	3	4	5	6	7	8	9
Academically	1	2	3	4	5	6	7	8	9
Spiritually	1	2	3	4	5	6	7	8	9

Was there a time in the last year that you felt you were coping well with this problem? ____Yes ____No

Anything else you feel that the counselor needs to know as you begin? ________________________________

____

____

Consent for Treatment and Confidentiality

I give my consent for Kathryn Zentner, LCSW to provide mental health services, including evaluation, individual and/or family therapy, parent coaching, and/or other services that we may mutually determine to be appropriate. I understand that whenever I am the client (or my child is the client) and I participate in therapy sessions the content of those sessions is confidential, i.e. verbal and written records about a client (and their parents) cannot be shared with another party without the written consent of the client or the client's legal guardian. Exceptions to confidentiality are as follows:

- A court of law subpoenas my records
- A client (or parent) discloses intentions or a plan to hurt another person
- A client (or parent) discloses or implies a plan for suicide
- A client (or parent) acknowledges abuse of a child (or vulnerable adult) by themselves or another

I also acknowledge that if I am asking for my insurance benefits to cover treatment the insurance companies and other third-party payers will be given information that they request regarding these services. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____ ____________________
Signature of Client or Parent/Guardian Date

____
Printed Name of Client or Parent/Guardian

Kathryn Zentner, LCSW

Licensed Clinical Social Worker

I truly appreciate the opportunity you have given me to be of professional service to you and/or your family. I am eager to receive your questions or concerns at any time. I look forward to a professional relationship with you.

My office policies are listed below. If you have any questions about them, please let me know._

OFFICE POLICIES

1. Sessions are 45 minutes long. Family or child play therapy sessions require extra preparation time and may be 30-40 minutes long, with the possibility of a parent "check in" time afterwards. You are expected to arrive at your appointment time.

2. My fee is $150 for the initial interview and/or assessment appointments, $125 for family therapy, and $125 for individual therapy. Longer sessions will be prorated based on the basic fees. Payment or co-payment is due at each session. Costs for court testimony are $500 per half day (or portion of a half day), payable in advance.

3. Regular attendance at scheduled appointments is one of the keys to a successful outcome in counseling. When you make an appointment, I reserve your appointment time for you. You are expected to notify me at least 48 hours in advance if you cannot attend a scheduled appointment. **Any cancellations within 24 hours of your appointment time will assess a $45 cancellation fee *regardless of the reason for the cancellation***. If you fail to keep an appointment without notice, I will charge you a $75 "no show" fee. These fees cannot be billed to insurance. You may cancel an appointment by calling or texting (512) 497-2177.

   I am aware of this cancellation policy: __________ (initials)

4. I will bill your insurance when applicable and as requested by you. It is your responsibility to make sure I am a participating (in network) provider on your plan and to know the limitations of your coverage. Your insurance company may limit the number of sessions based on their assessment of medical necessity or other factors. **Benefits quoted by your insurance company are not a guarantee of payment.** You are responsible for any co-pays, deductible amounts, and any other fees that are not covered by insurance. Payment is due at the time of service unless you have made special arrangements with me. In some cases I may ask you to supply a credit card as a secondary form of payment in case your claim is denied or you have not met your deductible.

5. Insurance companies routinely ask for patient information, including diagnosis and treatment plans to authorize payment. When you request that I bill your insurance company for my services, you are agreeing that I can release this information to them.

6. If you have an emergency or have an urgent need to speak with me, you may leave a message in my confidential voice mail box by calling (512) 497-2177. I attempt to return all calls within 24 hours. If I am not able to return your call within a reasonable amount of time, or I am unavailable for a longer period of time (i.e. on vacation), you are responsible for seeking help from community resources or the local emergency room or psychiatric hospital.

7. Throughout our time together we will discuss your treatment goals for therapy. Therapy is a joint effort between the therapist and client, the results of which cannot be guaranteed. Progress depends on many factors, including motivation, effort, and other life circumstances, such as interactions with family, friends, and other associates. Unfortunately, there are no instant cures and therapist and client must work together to move the client in the direction the client wants to go. You are encouraged to discuss any concerns and/or questions about treatment with me at any time.

I agree that I will be responsible for the payment of all professional fees. I have read and understand the policies listed above. I have received a copy of these policies for my records.

Signature of client (or parent/guardian) ____ Date_______________

Printed name of client (or parent/guardian) ____

Name of client (if client is a minor) ____