CLIENT INFORMATION

NAME: ____________________________ BIRTH DATE: ________________

ADDRESS:____

PHONE: H:____________________ W:__________________ C:_____________________

E-MAIL: ____

JOB TITLE: EMPLOYER:____

REFERRED BY:____

SEEKING INSURANCE REIMBURSEMENT? __________ YES __________ NO __________

MAYBE/IT DEPENDS____

CURRENT MEDICAL CONDITIONS or ISSUES:______________________________________

CURRENT MEDICATIONS (include over-the-counter, herbs, supplements):_________________

____
____
____
____
____
____

DO YOU: Smoke? __________ Drink? __________ Take recreational drugs? __________

DRUG(s) OF CHOICE:____

ARE YOU CURRENTLY ADDICTED TO ANY SUBSTANCES? _______ YES _______ NO _______ NOT SURE

WAS/IS ADDICTION AN ISSUE IN YOUR FAMILY OF ORIGIN? _______ YES _______ NO _______ NOT SURE

WHAT PREVIOUS COUNSELING/PSYCHOTHERAPY/PSYCHIATRIC TREATMENT HAVE YOU RECEIVED?

Please describe type of outpatient/inpatient treatment, issues addressed, and your view of the outcome:

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PLEASE LIST THE MAJOR LOSSES IN YOUR LIFE: (include deaths, relationship/divorce, financial, body injury or capacity, etc. and the year in which it occurred)

IF YOU HAD TO NAME THE 3 MOST IMPORTANT EVENTS/TRAUMAS/ACCOMPLISHMENTS THAT HAVE SHAPED OR IMPACTED WHO YOU ARE, WHAT ARE THEY?:

PLEASE RATE YOUR EMOTIONAL LITERACY (ability to identify and appropriately articulate what you're feeling) ON A SCALE FROM 1 to 10 (1 = low; 10 = high):
________ Fear ________ Anger ________ Sadness ________ Guilt ________ Shame
________ Joy/Contentment

WHAT ISSUES DO YOU WISH TO ADDRESS IN PSYCHOTHERAPY AT THIS TIME?

WHAT DO YOU SEE AS YOUR BIGGEST OBSTACLES TO MAKING CHANGES THAT WILL IMPROVE YOUR LIFE?
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IS SPIRITUALITY IMPORTANT IN YOUR LIFE AT THIS TIME?

Thank you for trusting me with your care and your emotions.

Sherry E. Showalter, Ph.D., LCSW, BCD, M.Msc.

Licensed Clinical Social Worker

POLICY AND FEE INFORMATION SHEET

CONFIDENTIALITY: confidentiality is maintained in accord with generally accepted ethical standards. Your written authorization is required for any release of information except in the event of court order or if you should indicate that you intend to harm yourself or someone else. The law also requires that your therapist inform Child Protective/Adult Protective Services if a child or adult is being injured.

SESSIONS: Each session lasts 50 minutes. 24-hour cancellation is required to avoid being charged for a missed session.

PHONE CALLS: There is no charge for brief phone calls. Calls lasting more than 15 minutes will be billed at the rate of $35.00 a quarter hour. Phone calls will be returned as soon as possible. Phone sessions will be billed at the standard rate plus any long distance charges that may be incurred. In an emergency it is suggested that you contact your nearest community mental health center or emergency room hospital.

FEES: Payment of <u>$120.00</u> for each individual or family psychotherapy session is due at each session. I do not bill insurance companies. Third party reimbursement cannot be guaranteed. Your therapist is licensed to practice psychotherapy in the state of Florida and Virginia. You may want to refer to your policy to see if you are covered for Licensed Clinical Social Work therapy sessions. Many insurance companies do not reimburse at all for therapy sessions. Cash or check can make payment. A bank charge of $35.00 will be billed to you for any returned check.

I have read the information regarding policy and fees and am in agreement with them and have been provided a copy

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Signature Date