Marsha Andre' LCSW-C
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Office Location:
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Glenelg, MD 21737

Mailing Address:
14230 Forsythe Road
Sykesville, MD 21784

Personal Information

Name______________________________ Today's Date__________________________

Address____________________________ Date of Birth___________________________

______________________________ Email ________________________________

Phone: home _________________cell ___________________work __________________

Referred by: ____

Policy Information

Please sign below indicating you understand and accept the following policies:

- I have been given the mandated privacy policy.
- I will be charged for counseling phone sessions (non-administrative calls more than five minutes)
- I am fully responsible for all fees charged for services (3.50% credit card fee)
- **I will be billed full office charge ($125.00) if my appointment is not cancelled by 8:00 AM the day prior to my appointment. Cancellations must be done by phone - not email.**
- Payment is due at time of service. An insurance form will be given to you for submission to your insurance every few weeks unless otherwise requested.
- If paying up front is prohibitive the provider may agree to submit for you. The reimbursement will be sent to provider and you are responsible to pay the co-payment at time of service.
- Late charges will be assessed on unpaid balances.
- It is your responsibility to call your insurance company and confirm your benefits.

Signed:____

Insurance Information

Please call and check on your insurance benefits such as deductible, co- pay, and if authorization is required prior to services rendered.

Primary Subscriber_____________________Relationship to Client________________________

Insurance Co Name____________________ 800 Mental Health Provider#__________________

Client ID #___________________________ Group # __________________________________

Payment Information

Please leave a credit card number on file, e-check information or pay by physical check weekly. The 3.50% charge assessed by your credit card company will be added to the charge

Check One: Master Card__________________________ Visa_______________________

Credit Card Number____

Cardholder Name (as it appears on the card)_____________________________________

Cardholder Address (as it appears on your credit card statement)_____________________

Expiration Date____

Cardholder Signature____

Note: I will have credit card receipts on file. The payments will be reflected on your monthly statement. If you would like separate copies please request them.

E-check Information

Bank Name____

Routing Number____

Account Number____

Signature____

All Financial Information is confidential and protected. If you have any further question please ask.

You are welcome to ask for a statement of your account at any time.

Informed Consent Regarding Limitations of Confidential Information

I understand that information about my treatment and communications with my therapist may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission, as explained below:

1. If necessary to protect my safety and the safety of others.
    a) If I am clearly dangerous to myself my therapist may take steps to seek involuntary hospitalization and may also contact members of my family or others.
    b) If I threaten to kill or seriously hurt someone and the therapist believes I may carry out my threat, or if the therapist believes I will attempt to kill or seriously hurt someone, my therapist may;
        - Notify the police
        - Arrange for me to be hospitalized
        - Tell any reasonably identified victim
2. If necessary for me to be hospitalized for psychiatric care.
3. If a judge thinks the therapist has evidence about my ability to provide care or custody in a child custody or adoption case.
4. In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.
5. If the therapist believes a child, disabled person, or an elderly person in my care is suffering abuse and neglect.
6. To provide information regarding my diagnosis, prognosis and course of treatment, or for purposes of utilization review or quality assurance, to a third party payer.
7. In a legal proceeding where I introduce my mental or emotional condition.
8. If I bring an action against the therapist and disclosure is necessary or relevant to a defense.
9. If necessary to use a collection agency or other process to collect amounts I owe for services.
10. If a court orders access to my records in a sexual assault or other criminal case.

I additionally authorize my therapist to consult professional colleagues if needed to enhance the clinical services I receive.

I have had the opportunity to discuss this informed con sent statement with my therapist. I understand its meaning and consent to receiving services based on this understanding.

Date____________________________ Client Signature___________________________

Therapist Signature________________________