CONTACT INFORMATION

Full Name: _____ Date of Birth: _____

Address: _____

_____

Phone: Please indicate if OK to leave message_____ (cell) Y N

_____ (home) Y N _____ (work) Y N

Email: _____

What is the best way to reach you? Cell Home Work Email

Emergency Contact: _____ Phone_____

Do you have a psychiatric advanced directive? Yes No

INSURANCE INFORMATION:

Carrier: _____

Subscriber Name (if different than client) : _____ DOB _____

Employer:_____

Member ID/ Subscriber #:_____

Group #:_____Policy #:_____

Provider Services Phone #:_____

Claim Address: _____

_____

# of sessions_____ Pre-auth needed?_____ Deductible_____ Copay_____

How were you referred to my practice? _____

Name: _____ **Date**_____

RELEASE OF INFORMATION AND CONSENT FOR TREATMENT

Informed Consent

- I understand the benefits, risks and limitations of psychotherapy and consent to receive mental health services from Michelle Risser, LISW-S. By signing this agreement I am entering into a therapist/ client relationship with Michelle Risser which legally protects my confidentiality and personal information.

  Initial_____

Policies, HIPAA and Bill of Rights:

- I have read, received a copy of and understand the psychotherapist patient-services agreement, confidentiality policy including exceptions and the HIPAA Privacy Statement and Patient Bill of Rights.

  Initial: _____

Insurance Claims and Credit Cards

- I grant Michelle Risser, LISW-S permission to provide and receive information necessary for processing insurance claims and collecting payment from third-party payers.

- I understand that insurance claims are processed electronically in Office Ally, a secure, encrypted and HIPAA compliant practice-management program. I understand that credit cards are processed in office with Square. If I elect to receive a receipt from Square I consent to the receipt being sent via email or text and I accept the risks associated with these means of communication.

  Initial_____

Confidentiality

- I have read and understand the privacy and confidentiality policy including the exceptions to confidentiality. I understand that session notes are stored electronically in Practice Mate™, a secure, encrypted and HIPAA compliant practice-management program. Paper files are kept in a secure, locked location.

  Initial_____

Communications

- I am aware of the limitations of electronic communications including email or text messages. While I understand that Michelle Risser, LISW will not knowingly compromise my information in any way, I do accept the inherent risks to privacy linked to these methods of communication.

  Initial_____

Signed:_____ Date:_____
(Client Signature)

Signed:_____ Date:_____
(Client Signature)

Signed:_____ Date:_____
(Provider Signature)

Name: _____ **Date**_____

CLIENT HISTORY

What are a few of the concerns you wish to address in therapy? Please list in order of concern:

1)_____

2)_____

3)_____

Medical History: _____

_____

_____

Current Medications _____

_____

_____

Allergies:_____

_____

Primary Care Doctor: Name _____ Phone_____

Do you give permission for me to consult with your primary care doctor about your care? Yes No

Previous Mental Health History (Please list previous diagnoses, medications and therapists)

_____

_____

_____

Do you have any concerns about alcohol or drug use? Yes No

If yes, please explain:

_____

_____

Education _____(highest grade completed) Major _____

Employer _____ Job Title _____ How long? _____

Do you have any particular religious affiliation? _____

Legal Issues or Concerns:_____

Children:

Name and Age	**Living with you?**	**Birthdate**	**Name of other parents**

Siblings:

Name and Age	**Living with you?**	**A few words to describe your relationship**

Where are you in birth order? _____

Are your parents still living? _____

Are your parents married?_____

Do you have any family concerns you wish to address?

_____

_____

_____