

Client occupation: [_____]

Client employer: [_____] How long: [_____]

Client employer's address: [_____]

City: [_____] State: [_____] Zip: [_____]

Spouse/Partner name: [_____] [_____] [____]

Last

First

MI

SS#: [_____] - [_____] - [_____] DOB: [_____] / [_____] / [_____] [____]

Age: [_____] Sex: M F

Occupation: [_____]

Employer: [_____] How long: [_____]

Employer's address: [_____]

City: [_____] State: [_____] Zip: [_____]

Client primary care physician (PCP): [_____]

City: [_____]

Phone number: [_____] - [_____] - [_____] [____]

How did you hear about Charles? [_____]

Insurance information

If using your insurance please provide the following information:

Name of Insurance Company: [_____]

Address: [_____]

City: [_____] State: [_____] Zip: [_____]

Phone: [_____] - [_____] - [_____]

Insured Name (The Employee): [_____]

Insured SS#: [_____] - [_____] - [_____]

Policy #: [_____]

Group # (if applicable): [_____]

Other information: [_____]

Your yearly deductible: [_____] What have you paid on the deductible: [_____]

Your copay: [_____] Number of sessions allowed per year: [_____]

Informed Consent

I have chosen to receive treatment services from Charles Lawrence Allen (CLA). My choice has been voluntary and I understand that I may terminate therapy and this contract at any time.

I understand that there is no guarantee of feeling better through psychotherapy. Because psychotherapy is a cooperative effort, I agree to work with CLA in a cooperative manner to establish a treatment approach to bring about resolution of mutually established goals.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that CLA report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that CLA report all cases in which there exists a danger to self and/or others.

I understand that I or CLA may be contacted by the insurance carrier to ensure continuity and quality of my treatment, and/or after the completion of treatment, to assess the outcome of treatment.

Your initials here: [_____]

The following four items are rights that you have as a patient:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse care.

I have read and acknowledge these basic rights.

Your initials here: [_____]

I agree to pay CLA for all services rendered and attest that I have been notified of said charges.

In the event that provided services are converted by private insurance, I hereby assign such benefits to CLA under said policy. I agree to notify CLA of co-pay amounts and/or deductible amounts that are my responsibility, and agree to pay them at the time of service according to my insurance policy directives.

I give permission for my signature on this contract to be used in place of an original one on the insurance claim form.

I further consent to the release of information necessary to obtain payment. I understand that CLA may disclose any and all records pertinent to my treatment to my insurance representatives (and to my primary care physician), if such disclosure is necessary for claims processing, case management, quality assurance, or utilization review purposes.

I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

Should my account fall into arrears, I agree to pay costs should this matter be referred to an attorney or a collection agency.

Your initials here: [_____]

Late cancellation policy:

"I am making a commitment to you in scheduling an appointment for you and I expect you to make that same commitment." - CLA

All appointments must be cancelled by 24 hours in advance to avoid charges for a no-show or late-cancellation. Please be prepared to pay a no show fee of \$30 when calling to reschedule a session you have missed or did not give proper 24 hour notice. Please do not put the secretary in the uncomfortable position of having to ask for the payment, let her know that you are ready to make the payment and do so at that time.

Your initials here: [_____]

About Charles Lawrence Allen

Charles is a psychotherapist - trained in therapy methods to help individuals manage a variety of mental health and daily living problems toward improvement of overall functioning. He has been in practice for over 20 years. He has extensive experience in treating people from all walks of life.

His role is to do talk therapy. Therapy occurs after specific problem identification and specific goal setting. You and he work together toward problem resolution and accomplishment of goals.

You may choose to consider medication as a method of helping you toward symptom reduction or mood improvement; in that case he can assist you in making that choice. Psychotherapy and use of medication can be done at the same time and can be an effective choice for many people.

Charles is not a physician or psychiatrist who prescribes medication. Also, he is not a psychologist who might do an in-depth assessment, in-depth evaluation, or a diagnostic work-up. If you need one of those services he will help to make a referral for you.

Initial therapy notes are very brief. Progress notes after that are limited to a basic description of the results of that session and the goal(s) of the next session.

Your initials here: [_____]

IMPORTANT: Charles will not be documenting information for your use in a court of law – this includes but is not limited to cases of divorce, child custody, short or long term disability. He will not be able to document or fill out paperwork for your short or long term disability case either for your employer, your human resources department, your lawyer, or for you personally.

Your initials here: [_____]

By signing below you confirm that you have read, had an opportunity to ask questions about, and understand the above six (6) page document and its contained information with regard to Charles Lawrence Allen, Inc.'s contract for therapy, notice of privacy policies, consent for treatment, insurance assignment, and descriptions and limitations of services.

Print Client Name

Signature of Client

Print Witness Name

Signature of Witness