STACEE PALEY COUNSELING, LLC

Treating Therapist _____ Today's Date _____

Client Legal Name _____ Birthdate _____

Preferred Name _____ Preferred Pronoun _____

Address _____

City _____ State _____ Zip Code _____

Referred by _____

Previous counseling? YES / NO If YES, name/location _____

Reason for seeking help? _____

_____

*If client is **MORE THAN** 14 years old*:

Cell# _____Email _____

Voicemail? YES / NO Text? YES / NO Email Appointment reminder? YES / NO

EMERGENCY CONTACT:

Name_____Relationship_____Cell# _____

*If client is **LESS THAN 14** years old:*

Parent/Guardian _____

Cell#_____ Email _____

Voicemail? YES / NO Text? YES / NO Email Appointment reminder? YES / NO

Parent/Guardian _____

Cell#_____Email _____

Voicemail? YES / NO Text? YES / NO Email Appointment reminder? YES / NO

PAYMENT OPTIONS: Circle one: SELF PAY or INSURANCE If SELF PAY, I agree to rate of $_____

If INSURANCE, Company _____ Member ID# _____

Annual Deductible $_____ with Effective Date of _____ and Copay of $_____

Did you call for Pre-Authorization*? NO / YES If YES, Pre-auth # _ _____

---- please turn over for more information ----

***MANY INSURANCE COMPANIES REQUIRE PRE-AUTHORIZATION FOR MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICE. IF THIS IS REQUIRED BY YOUR INSURANCE CARRIER AND YOU DID NOT CALL, BE AWARE THAT YOU MAY BE PENALIZED WITH DENIAL OR REDUCED BENEFITS.**

SPC will submit electronic insurance encounters as a courtesy if FULL INSURANCE IS PROVIDED. It is up to the client to know his/her insurance coverage, including knowledge of copayment amounts, and annual deductibles. ***Please note: SPC may look up client insurance coverage, but it is NOT A GUARANTEE OF COVERAGE, deductible or copayment amount. If payment for services has not been satisfied by the insurance company within 90 days, it is the responsibility of the client or parent/guardian to pay the bill in full.***

I read and understand pre-authorization and patient payment responsibility. **Initial_____**

MISSED APPOINTMENT AND CANCELATION POLICY.

Please contact the office at least 24 business hours before appointment to cancel or reschedule. Clients/parents/guardians will be charged for session time up to the full fee allowed by individual insurance company (not copay rate) or full self-pay rate.

I read and understand MISSED APPOINTMENT AND CANCELATION POLICY. **Initial_____**

MEDICATIONS Are you currently taking any medications? YES / NO If YES, please list below:

Medication	Dosage	Frequency	Start Date

Name of who prescribed medication _____ Telephone _____

Allergies? YES / NO If YES, please list: _____

Please list any substances you currently use if any*: (Alcohol, cigarettes, etc.)*

Substance	Frequency	Amount	Date of Most Recent Use	Age Started

Acknowledgement of Psychotherapist-Client Services Agreement

Please read, initial, sign and date the following.

_____ I have read and understand the PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT, including the client's rights and responsibilities during their treatment under Stacee Paley Counseling, LLC.

_____ I have read and understand the PRIVACY PRACTICES outlined by HIPAA.

_____ I have read, understand and agree to the RULES OF CONFIDENTIALITY.

_____ I have read and understand the 24-HOUR CANCELLATION POLICY and the client's responsibility to FEES and APPOINTMENTS.

_____ I have read and understand the LIMITS TO ELECTRONIC CONFIDENTIALITY when dealing with fax, email and other electronic correspondence.

_____ I have been provided the opportunity to discuss the PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT with my therapist, or any associate of Stacee Paley Counseling, LLC, and ask questions regarding this CLIENT CONTRACT and the contents within.

My signature below indicates that I, as a client/parent/guardian, have read the PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT, and I understand and agree to its terms. I also understand that I may request a copy of these notices.

_____ _____

Client Signature (if 14 years of age or older) Date

If client is under the age of 14 years:

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date