Counseling Care Specialties

Margie Freeman LCSW

Welcome! I look forward to serving you!

STATEMENT OF POLICY AND INFORMED CONSENT

1) Therapy sessions are approximately 45 minutes. Please arrive on time for sessions. If you are late, you will have the remaining time in your 45 minutes. If I am running late, you will still be provided with the full 45-minute session.

2) Cancellation of sessions requires a minimum of 24 hour notice or you will be charged a fee for the session, except in rare cases or emergency situations. In some instances, a phone session can be arranged in lieu of an in-person session, or a fee can sometimes be waived if a session can be rescheduled within the same week.

3) Payment is due at the time of the session: cash or check payable to Margie Freeman. Please have your check or cash ready in advance and pay as you enter. For self-pay clients, the initial diagnostic session is $160.00. Therapy sessions thereafter are $150.00, regardless of whether it is an individual or a couples' session. If you are an insurance client, co-payments are due at each session. I can provide you with a statement of your payments upon request. (EAP sessions do not generally have a co-pay.)

4) If you have been authorized by your insurance for a certain number of sessions, please let me know two sessions prior to the expiration of your sessions, so that I can submit your treatment request form in sufficient time to avoid gaps in service.

5) I will do my best to return calls in a timely fashion. However, I do not answer calls while I am in session with clients. Calls between sessions should be limited for appointment scheduling, unless you opt to schedule a phone session, which is billed at the same rate as an in-person session. Please note that I do not provide 24-hour emergency services. In case of emergency, please call 911 or your local criss hot line.

6) The privacy and confidentiality of sessions and records is legally and ethically protected by State law and Federal law in all but a few rare circumstances which will be discussed in more details during the initial session.

I acknowlege the fact that all information pertinent to billing is being sent to: Solinmed LLC, 15908 Alvarado Drive, Prosper, TX 75078

Name of Client: _____

Address of Client: _____

Signature of Client: _____ **Date:** _____

Name of Witness: _____ **Signature of Witness:** _____

(Copy of Statement of Policy can be obtained upon request.)

356 Redmond Road, S. Orange, NJ 07079 | (973) 220-9007 | www.margiefreeman.com

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ADULT CLINICAL QUESTIONNAIRE

Briefly describe what problems or concerns bring you here _____

List any current health problems _____

List any serious illnesses/accidents in your life _____

Allergies ☐ **yes or no** ☐ **If yes, what?** _____

Smoker ☐ **yes or no** ☐ **If yes, how much?** _____

Drugs Used _____ ***Last Use*** _____

(prescribed, OTC, alcohol, illicit)

Frequency/Quantity/Dosage _____

_____

Have you previously received counseling of any kind? ☐ **yes or no** ☐

***If so:* Date of counseling** _____ **Duration** _____

Purpose _____

_____

Circle any of the following concerns that pertain to your FAMILY history:

alcoholism drug abuse verbal abuse physical abuse sexual abuse depression

anxiety panic attacks suicide attempt/completion psychiatric hospitalization

Circle any of the following concerns that pertain to your PERSONAL history:

alcoholism abortion adoption depression suicidal thoughts/attempts temper

ADD/ADHD same sex relationship anxiety panic attacks drug abuse DUI

verbal abuse physical abuse sexual abuse adult rape psychiatric hospitalization

eating disorder legal matters divorce financial stress homicidal thoughts/attempts

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CLIENT INFORMATION SHEET - PAGE 1

Name _____ *Date* _____

Address _____

City _____ *State* _____ *Zip* _____

Phone: Home _____ Message Can Be Left ☐ Yes or ☐ No

Work _____ Message Can Be Left ☐ Yes or ☐ No

Cell _____ Message Can Be Left ☐ Yes or ☐ No

Email _____

Date of Birth _____ *Social Security #* _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Status: ☐ Single ☐ Married ☐ Other Male or Female

☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Is Condition Related To:

Employment: ☐ Yes or No ☐ If Yes: Current ○ or Previous ○

Auto Accident: ☐ Yes or No ☐ State _____ Other Accident: ☐ Yes or ☐ No

Insured's Name _____

(If you, the client are also the insured, write same as above. If you, the client are not insured, please fill in)

Address _____

City _____ *State* _____ *Zip* _____

Phone: Home _____ Work _____

Date of Birth _____ *Social Security #* _____

OFFICE USE: Doctor Name (if group)

Dx: _____

CPT: _____

Fee: _____ **First Date of Service** _____

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CLIENT INFORMATION SHEET - PAGE 2

Patient Name _____

Insurance Company _____

Address _____

(from back of Insurance Card)

City _____ ***State*** _____ ***Zip*** _____

Phone _____ ***Employer*** _____

Insurance ID # _____

Group / Policy # _____

Secondary Insurance (if applicable):

Insured's Name _____

Address _____

City _____ ***State*** _____ ***Zip*** _____

Phone: Home _____ ***Work*** _____

Date of Birth _____ ***Social Security #*** _____

Secondary Insurance Company _____

Address _____

(from back of Insurance Card)

City _____ ***State*** _____ ***Zip*** _____

Phone _____ ***Employer*** _____

Insurance ID # _____

Group / Policy # _____