Counseling Care Specialties

Margie Freeman LCSW

Welcome! I look forward to serving you!

STATEMENT OF POLICY AND INFORMED CONSENT

1) Therapy sessions are approximately 55 minutes. Please arrive on time for sessions. If you are late, you will have the remaining time in your 55 minutes.

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 of emergency situations. In some instances, a fee can some times be waived if a session can be rescheduled within the same week.

3) **Payment is due at the time of the session or before:** Venmo payable to @MargieFreemanLCSW or Zelle payable to (973) 220-9007. I can provide you with a statement of your payments upon request. EAP sessions do not generally have a co-pay, but require an authorization number. Since each client's policy is different, please check with your insurance in advance to find out what your benefits are.

4) Since Covid, all sessions are being held on HIPAA- compliant version of Zoom. I spend the winter in Florida during which time all sessions are held online. When I am in NJ we can decide whether we will meet virtually or in person depending on the latest covid rate status.

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. I also observe the Jewish Sabbath, so communications from Friday sundown through Saturday sundown will be responded to after the Sabbath. 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. 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 can be discussed in more detail during the initial session.

7) When you have achieved your counseling goals or want to stop, we will schedule a minimum of one session for review, feedback, and conclusion.

I acknowlege the fact that all information pertinent to billing is being sent to:
R. LEVIN | Boynton Beach, FL 33472

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.)

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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 Female Non-Binary**

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:

Dx: ______________________________________

CPT: ______________________________________

Fee: ______________________ **First Date of Service** ______________

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CLIENT INFORMATION SHEET - PAGE 2

Client 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 # ______________________________

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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

PLEASE SAVE & SEND COMPLETED FORM TO *MaregieFreemanLCSW@gmail.com*