

# Counseling Care Specialties

Margie Freeman LCSW

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***Welcome! I look forward to serving you!***

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## 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 acknowledge 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 # \_\_\_\_\_

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### 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 # \_\_\_\_\_

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### 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

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PLEASE SAVE & SEND COMPLETED FORM TO [MargieFreemanLCSW@gmail.com](mailto:MargieFreemanLCSW@gmail.com)