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 # _____

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

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ADULT CLINICAL QUESTIONNAIRE

Name: _____

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 *MargieFreemanLCSW@gmail.com*