Counseling Care Specialties

Margie Freeman LCSW

STATEMENT OF POLICY AND INFORMED CONSENT 1 of 2

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) 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.

5) 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.

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

7) I/we authorize Margie Freeman, to video record our couples therapy sessions (and, at times, individual therapy sessions), whether conducted online or in person, if mutually agreed upon. (Opt in or out one next page)

I/We understand the following:

A. Purpose: Recording sessions is a standard part of my practice and my continuing professional development as a therapist.

B. Ownership & Use of Recordings
Margie Freeman owns the video/audiotapes, which are not a part of our personal medical records. Recordings may be shared with Relational Life Institute ("RLI") and RLI consulting therapist for the sole purpose of receiving supervision and peer review. RLI"s group supervision participants are all bound by the ethical standards of confidentiality for therapists and coaches.

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C. Storage:

Recordings will be stored in a secure and confidential manner. RLI will maintain secure, confidential storage and will delete recordings immediately after case review.

D. Clients' Rights & Privileges:

During a session, either client may request that recording be turned off at any time, or that any portion of the recording be erased. Either client has the right to withdraw consent to record at any time. Withdrawal of consent can be invoked by the client during a session followed by e-mail request, which will be confirmed by the therapist. Recordings and disclosures once submitted to RLI made based upon our original authorization cannot be withdrawn. Clients will receive a copy of this authorization after signing. A copy is as valid as the original.

E. Duration:

This authorization shall terminate two years from the date of signing below unless revoked prior to such date.

Select one option:

I consent to video recording of sessions.

I do not consent to video recording of sessions.

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

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD ALL OF THE TERMS OF THIS STATEMENT OF POLICY AND INFORMED CONSENT AUTHORIZATION. (TO BE SIGNED BY BOTH PARTNERS)

Name of Client: ______________________________

Address of Client: ______________________________

Signature of Client: ______________________________ **Date:** ______________

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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

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*