

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 of emergency situations. In some instances, a phone session or Doxy.com 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:** Venmo payable to @MargieFreemanLCSW or cash or check payable to Margie Freeman. **Please have your payment ready in advance and pay as you enter.** For self-pay clients, the initial diagnostic session is \$220.00. Therapy sessions thereafter are \$200.00, 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) Please note that I will be spending winters in Florida. During that time, we can arrange on-line counseling via Doxy.com, pending signing of on-line counseling contract.
- 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 | 713 Halsey Street, Brooklyn, NY 11233**

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 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 # _____

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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