Jon Picker, LPC
www.Creative Therapy Center.Net

Chief Reason for being here today: _____
Referral Source: _____
Current Medications: _____
Current Doctors: _____
Previous/current Therapists and dates of treatment: _____

Client Information:
Name: (First, Middle, Last) _____
Sex: (circle one) Male Female Date of Birth: _____ Age: _____
Social Security Number: _____ Marital Status: _____
Mailing Address: _____ City: _____ Tx Zip: _____
Email: _____
Phones: Hm: _____ Wrk: _____ Cell _____ Preferred? ____
Client's Employer/School: _____ TDL: _____
If employed or in school, circle one: part time or full time
If client is a child, Parent's Name (s) _____

Financial Responsibility:
Person responsible for payment (if different from client) _____
Relationship to client: _____
Employer: _____
Phones: Hm: _____ Wrk: _____ Cell _____ Preferred? _____
Date of Birth: _____ Age: _____ TDL: _____
Address: _____ City: _____ Tx Zip: _____

Credit Card:
Card Type: (circle one): Visa Master Card Amer Xpress Card Number: _____
Expiration Date: _____ Name as Printed on Card: _____
Verification/Security Code (3 digit code on back of card near signature line): _____

Insurance Information:
Primary Insurance Co: _____ Phone: _____
Name of Policy Holder: _____ DOB: _____ SS #: _____
Employer: _____ Group#: _____ Policy #: _____

Secondary Insurance Co: _____ Phone: _____
Name of Policy Holder: _____ DOB: _____ SS #: _____
Employer: _____ Group#: _____ Policy #: _____

Person to Notify in Case of an Emergency:
Name: _____ Relationship to client: _____
Phones: Hm: _____ Wrk: _____ Cell: _____ Preferred? _____
Address: _____ City: _____ Tx Zip: _____

I authorize the release of any medical or other information necessary to process this claim. (Most insurance companies require that I report a mental health diagnosis for you.) I authorize payment of applicable medical or behavioral health benefits to Jon Picker, LPC. **I authorize Jon Picker, LPC to use my credit card information to charge my credit card if I do not cancel a scheduled appointment or if a check is returned for insufficient funds or if my insurance company does not pay as expected.** This form will be securely stored in your clinical record and may be updated upon request at any time.
I also give permission for Jon Picker to send correspondence through email, USPS, or to telephone me if needed.

_____ _____
Signature of Client, Parent or Guardian Date

Consent to Treatment:

It is important for you to be aware of the benefits and limitations of psychotherapy or other services you receive. While it is generally expected that you will benefit from therapy, there may be periods of feeling worse before feeling better. Much of the benefit of therapy depends on the work *you* do. There is no guarantee of success. I can promise that if you are dissatisfied with your treatment for any reason, I will listen to you about your concerns. One of the best ways to resolve problems is through honest communication. Therapy is the place to practice communicating!

Many people want to know, "how long will therapy last?" The answer is different for each person depending on the presenting issues, your motivation, your goals and multiple variables neither you nor I can predict nor control.

Fees/Policies:

You are ultimately responsible for payment of all charges. Full payment may be requested prior to insurance approval. Payments, including co- payments and deductibles are due at each session. It is your responsibility to notify me if your insurance changes. Otherwise, you will be financially responsible for any sessions that required pre-certification by your new insurance company. Clients who have an outstanding balance might not be scheduled for further sessions until the balance is paid in full. Receipts, statements or other documentation will not be furnished to clients with unpaid balances.

Missed/Late Cancellation of Appointments:

I plan 50 minutes devoted to face to face contact with you. If you do not cancel or reschedule your appointment within 24 hours I will charge you $50 for the time I would have spent with you. Insurance does not pay for missed appointments.

Emergencies:

If you call me, I'll return your call. I generally return calls the day they are received; calls received in the evening might not be returned until the next day. If immediate care or service is needed, call 911 or go to the nearest emergency room.

Telephone Consults:

I do want to be reasonably available between sessions. If your call lasts more than 10 minutes you will be charged on a prorated basis according to the hourly fee for individual therapy. Insurance does not pay for telephone consults.

Dual Relationships:

As a Licensed Professional Counselor, (LPC) I am not permitted to have any kind of relationship with a client other than the client-therapist relationship. I am not allowed to have a social relationship or business relationship with a client.

Your Right to Privacy:

I will make a record of your treatment. This record is your protected health information (PHI) and is protected by law. The law requires that your privacy is protected and that you are informed of your rights regarding (PHI). Your rights regarding your PHI: 1. to complain to me or to the Secretary of Health & Human Services if you believe your privacy has been violated; 2. to ask for restrictions on certain uses and disclosures, but I am not required to agree to the requested restriction; 3. to have a copy of this notice; 4. to review your PHI with me and at my discretion; 5. to request an amendment of your PHI but I am not required to make such an amendment; 6. to know how your PHI has been disclosed; 7. to receive an account of disclosures of your PHI. I will protect your privacy to my best ability. For example, I will not disclose information to your family, employer, physician or peers without your specific written consent. If you give such consent, you may also revoke the consent. I am required by law to report incidences I believe to be abusive or neglectful to children, disabled or elderly people. If you are in imminent danger of hurting yourself or others I will notify proper authorities. Psychotherapy notes are not "privileged" and may be subpoenaed to Court. If the law requires, I may disclose information to public health or legal authorities charged with preventing or controlling disease, injury or disability or with law enforcement in very specific circumstances.

I know I may have a copy of this form for my records.

Client Signature: _____ Date: _____ Other Signature: _____ Date: _____