Diane Moskowitz, M.A. **Licensed Professional Counselor**

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T0 MY NEW CLIENTS:
Welcome to my practice. Please read the following policies, and feel free to discuss with me any questions or concerns you may have before signing below.

CONFIDENTIALITY: The confidentiality of your therapy is protected by law. Your written consent is required to release any information. Exceptions to confidentiality are limited to extreme circumstances: threat of serious harm to you or others; suspected child or elderly abuse or neglect; a medical emergency; or a court order. Also, if you are using insurance, you will be required to authorize the release of any treatment information necessary to process claims or obtain authorizations for treatment. Depending on your insurance , information may range from a psychiatric diagnosis (the minimum) to a more detailed description of the problems we are addressing and your mental stability. I will, of course, discuss with you any information I am sending to your insurance company. Couples confidentiality: If you are being seen with a partner or family member, I will require signed releases from both of you before I will release information or consult with a third party.

APPOINTMENTS: Each session is usually 50 minutes in length, unless otherwise arranged. Appointment times are held exclusively for you. If you are unable to keep your appointment, please give me as much notice as possible. If you do not call my voice mail or email me at least 24 hours in advance, you will be charged at the usual fee. If you are using insurance for your treatment, please note that they will not pay for a missed session. Emergencies will be considered on a case by case basis.

TELEPHONE AND EMAIL COMMUNICATION: My telephone is connected to a 24-hour voice mail system. I check for messages several times a day during working hours, and I will return your call as soon as possible. If I am on vacation, one of my associates will be on call. I use email for scheduling and other logistical issues. Please do not include personal information in an email, as I cannot guarantee its confidentiality. I cannot respond to urgent issues by email.

FEES AND INSURANCE: My fee is $135 for individuals, $150 for couples, for a 50-minute session. There are additional charges for letters, reports and extended telephone time. I accept payment by check, cash, or VISA and MasterCard. The fee is payable at each session unless I have a contract with your insurance company that requires me to bill them directly. In that case I will collect your co-payment at each session. Otherwise I will provide an insurance claim form for you to submit directly to your company. Please carefully consult your insurance company's mental health coverage. Insurance companies vary greatly in the types of problems they cover, the length of treatment provided, and the therapists you can select from in order to receive reimbursement. I am a Licensed Professional Counselor and a provider for several preferred provider groups. I will assist you in clarifying your insurance company's coverage for my services. Please note that I reserve the right to submit delinquent accounts to an attorney or collection agency. In that event, your confidentiality will, by necessity, be breached.

CONSENT TO TREATMENT: Your signature below indicates that you have read and agree to the policies stated above. If, at any time, you have concerns or questions regarding your therapy, please discuss them with me. Remember that you have the right to refuse treatment at any time, and to request a referral to another therapist.

Thank you for choosing me as your therapist.

Signature_____Date_____

BACKGROUND INFORMATION Today's Date_____

Name_____Birth date_____Age_____

Address_____City_____State_____Zip_____

Telephone #'s: Work_____Home_____Cell_____

email_____

What's the best way to reach you? Please check one: Phone_____or e-mail _____

Emergency Notification_____Relationship_____Phone_____

Names/Ages of Children_____

Relationship Status: Single _____Married_____Divorced_____Separated

Occupation_____Employer_____

Education_____

By whom were you referred?_____Phone_____

May I send a thank you note to the person who referred you? Yes_____ No_____

MEDICAL INFORMATION

Name of your physician_____Date last seen_____

What prescription and non-prescription medications are you currently taking?

Drug Name	Dose	Prescribed for	Date of initial Rx

Other significant medical problems_____

Please describe the following

Frequency and amount of alcohol use_____

Quantity of cigarette smoking_____

Amount of caffeine use_____

Frequency and type of exercise_____

Amount of sleep per night_____

PREVIOUS COUNSELING EXPERIENCE:

Have you ever been in counseling before? Yes____ No_____If yes, please describe below.

1. Therapist's name_____Approx. dates seen_____

2. Therapist's name_____Approx. dates seen_____

Psychiatric hospitalizations? Yes_____No_____ Dates_____

CURRENT PROBLEMS:

Please describe briefly what changes you are hoping to make in coming to counseling now.

_____

_____

_____

Please check any of the following symptoms you have experienced in the past month.

__Depression
__Extreme sadness
__Memory problems
__Weight changes
__Self-esteem problems
__Perfectionism
__Problems with anger
__Feeling anxious
__Feeling tearful
__Physical pain
__Thoughts of hurting yourself or others
__Feeling hopeless
__Trouble concentrating
__Lack of energy
__Feeling stressed
__Easily irritated
__Feeling guilty
__Feeling fearful
__Acting violently
__Muscle tension
__Feelings of panic
__Obsessions or compulsions
__Change in sleeping habits
__Change in eating habits
__Feelings of extreme happiness
__Change in sexual interest or function
__Problems getting along with family
__Trouble performing your job
__Lack of enjoyment of usual activities
__Impulsive behaviors
__Poor judgment
__Thoughts of killing yourself or others

INSURANCE INFORMATION;

Name of insurance company_____Phone_____

ID#_____Employer_____

Name of Insured_____Group#_____

Relationship to insured: Self_____Spouse_____Child_____Other_____

I authorize payment of medical benefits to the provider of services and the release of any treatment information necessary to process claims or obtain authorizations for treatment.

Signature_____Date_____