Virginia (Ginny) Powell, LCSW, BCD

INITIAL INTERVIEW FORM

CLIENT INFORMATION:

Date: ____________

Name: ________________________________ Marital Status: __________
Phone: (Cell) ______________ (Wk) _____________ (Hm) ____________
Address: _____________________________ City: ___________________
State: ________________________________ Zip: ___________________
Sex: Male _________ Female _________ Date of Birth: _______________
Others living at home: ____
Employer: ______________________ Occupation: ____________________
How long have you worked there? _______ How long in this occupation? ______
Education: (List highest level of education attained) __________________
Primary Physician: _______________________ Phone: ________________
List any significant health problems: ______________________________
____
List any medications you are taking and the dosage: ___________________
____
Have you seen this type of therapist before? YES _______ NO _______
If yes, when and with whom? _____________________________________
Give a brief description of treatment: _______________________________
____
How were you referred to our office? ______________________________
Who may we thank for referring you? ______________________________
Nearest relative other than spouse: ________________________________

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name: ____________________________ Relationship to Client: __________
Phone (if different from above): ___________________________________
Address (if different from above): __________________________________
Insurance Carrier (if applicable): __________________ Phone # ___________
Social Security Number of Insured: __________________________________
Group Number: __________________ Member ID Number: ________________

INFORMED CONSENT

CONFIDENTIALITY STATEMENT:

All information shared in this treatment is confidential except in circumstances governed by law. If you would like me to confer with another healthcare professional, you will need to sign a "Release of Information" form. This permission can be revoked by you at any time.

FINANCIAL AGREEMENT:

The initial session is normally $100 and subsequent sessions are $90 each, unless agreed otherwise. Your fee per visit is $________payable at the time of treatment.

If you are insured for this treatment, you are responsible for coordinating initial benefit authorizations (if necessary) between your insurance company or managed care insurance plan and this office (via Sara Connors Billing Service). We will assist you in billing your insurance, but ultimately you are responsible for payment of services at full fee or the contracted rate of your managed care plan. You will be responsible therefore for any deductibles, co-pays, or non-payment by your insurance.

If you already know of a co-payment, please enter the amount you will be paying each week for your treatment:__________.

NO-SHOW AND CANCELLATION POLICY:

Your visit has been reserved for you. 24 hours notice is required for cancellation or you will be charged a late cancellation fee of $__________.

EMERGENCIES:

Please call my cell number which is (619) 971-0320. A back-up resource is the San Diego Crisis Line at 1 (800) 479-3339, or if it is a life threatening emergency call 911.

STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent.

Client:________________________________ Date:________________

Provider:______________________________ Date:________________

Parent or Guardian if minor_______________Date:________________