Heidi L. Parker, LCSW
PO Box 770, Round Lake, NY 12151 p 518.871.3638 / f 518.662.7446

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address:_____

Cell Phone: _____ Okay to leave messages? _____ Okay to text? _____

Home Phone: _____ Okay to leave messages? _____

Work Phone: _____ Okay to leave messages? _____

Email: _____

Sex: [ ]Female [ ]Male [ ]Prefer to discuss in session

Employer: _____ Occupation: _____

School *(if student):* _____ Grade/Year: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

IF CLIENT IS UNDER 18 YRS. OF AGE

Parent Name: _____

Parent Cell Phone: _____ Okay to leave messages? _____ Okay to text? _____

Parent Address *(if different than above):* _____

Parent Email: _____

INSURANCE INFORMATION

Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Address *(if different than above):* _____

Policy Holder Phone *(if different than above):* _____

Policy Holder is: [ ]Client [ ]Spouse [ ]Parent [ ]Other

Policy Holder Employer: _____

If there a Secondary Insurance Company, please identify: _____

By signing below, I authorize Heidi L. Parker to bill my insurance company for psychotherapy services rendered. If Ms. Parker does not accept my insurance, I have agreed to pay the full session fee at the rate discussed.

Client *(or Parent/Guardian)* Signature: _____ Date _____

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INFORMED CONSENT FOR TREATMENT, PRIVACY, & PRACTICE POLICIES

I understand that the practice of psychotherapy is not an exact science and results cannot be guaranteed. I agree to provide accurate information about myself and to play an active role in my treatment process. I am aware that what I discuss in treatment will be treated confidentially and in accordance with the law and recognized professional standards.

Privacy: I have read and understand the Privacy Policy. I understand that my personal health information may be used for treatment, payment, or administrative purposes. If I have agreed to communicate with Heidi L. Parker via email, text, or voicemail, I understand that confidentiality cannot be guaranteed. If I wish to restrict use of my information, I will send Ms. Parker a written request describing these restrictions. I understand that I can alter or revoke my consent, in writing, at any time. These consent changes will have no effect on information used or shared by Ms. Parker prior to receipt.

Telehealth Sessions: I understand that while privacy will be protected during telehealth sessions, it cannot be guaranteed. It is my responsibility to secure privacy in my personal surroundings. I am aware that remote communication can be unreliable and telehealth sessions are frequently impacted by technology failures.

Payment and Cancellations: I understand that payment is due at the time of service. I am aware that appointment cancellations require 24-hour notice (1 full business day) and that I am responsible for a $75. cancellation fee if such notice is not provided. I acknowledge that I am financially responsible for all unpaid balances on my account.

Insurance: Unless I am paying privately, it is my responsibility to understand my insurance benefits and inform Ms. Parker of any changes. I permit the release of information to process claims for insurance reimbursement. I also understand that my insurance carrier may insist on auditing or inspecting my treatment records.

I understand that I may terminate my therapy at any time. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent. I understand that Ms. Parker does not accept clients that require court appearances and will notify her immediately if this applies.

My signature below shows that I understand and agree with all statements in this Informed Consent.

Signature of Client (or Parent/Guardian): _____ Date: _____

Printed Name: _____ Relationship to Client: _____

CREDIT CARD INFORMATION

Credit Card #: _____ Exp. Date: _____ CV Code *(on back):* _____

Cardholder Name: _____ Phone: _____

Billing Address: _____ City/State/Zip: _____

(Note: You may provide your information directly rather than in writing. Please fill in card number above, sign below, and speak with Ms. Parker regarding remaining information.)

By signing below, I authorize Heidi L. Parker to charge my credit card for payment of psychotherapy services, including session fees, cancellation fees, and any insurance co-payments/co-insurances/deductibles.

Cardholder Signature: _____ Date: _____