

OFFICE OF DEBBIE GRANOVSKY, LCSW
Patient Registration

Please Print Legibly

Date _____

Patient's Name _____ Sex _____

Address _____

Home Phone (___) _____ Work Phone (____) _____

Cell Phone (____) _____ Put a * if OK to leave a confidential message

Date of Birth _____ Age _____

Referred By _____

Employer _____

Position or Occupation _____

Marital or relationship status _____

Emergency Contact _____ Relation to you _____

Phone # _____

Permission to contact emergency contact in case of emergency? Y or N

Please sign below after reading Office Policy and Statements of Clients' Rights and Responsibilities on next page.

I have read, understand, and accept the Office Policies and Statements of Clients' Rights and Responsibilities. I agree to these conditions.

Signature _____ **Date** _____

OFFICE OF DEBBIE GRANOVSKY, LCSW

IMPORTANT: PLEASE READ

OFFICE POLICIES

- **Payments:** Payment is requested **at the time of each visit**, by Cash or Check.
- **Appointments:** Cancellations- for any reason- **require 24 hours notice**. Because I've blocked out the appointment time for you, the full fee will be charged in case of inadequate cancellation time.

STATEMENT OF CLIENTS' RIGHTS

Clients have the right to:

- Be treated with dignity and respect.
- Receive fair treatment; regardless of their race, religion, gender, ethnicity, sexual orientation.
- Have their treatment and other information kept private. Only where permitted by law, may records be released without client's permission.
- Identify their goals for treatment. Set the pace of treatment.
- Know of their rights and responsibilities in the treatment process.

STATEMENT OF CLIENTS' RESPONSIBILITIES

Clients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give therapist the information she needs. Let therapist know if treatment is working for them. Give honest feedback to therapist.
- Ask questions about how therapy works; make sure they understand role of therapist and of client.
- Ask their doctor (if they have one) about medicines that are being prescribed and make sure they understand what is being prescribed and why.
- Keep their appointments. Let therapist know about problems with keeping appts.
- Understand 24 hour cancellation policy and know that they will be charged in full if 24 hours notice is not given.

Please keep for your reference

FEES, INFORMED CONSENT, AND AUTHORIZATION

1. I request counseling from Debbie Granovsky, LCSW.
2. I understand that each session is 50 minutes in length, this includes administrative tasks such as, payment for session and scheduling next session. Starting and ending on time is important.
3. Full payment (of the established fee) by cash or check, is due at the time of the session. However, other billing arrangements may be made on a case-by-case basis.
4. In the unlikely event that check funds are dishonored, I understand that I will be charged a \$30. processing fee, in addition to the value of the original check.
5. Appointment Cancellations: I understand that cancellations require 24 hours notice. If 24 hours notice is not given, the full fee (up to \$120.) will be charged. Charges are based on the time Ms. Granovsky reserves to work with me.
6. If I request my counselor to fill out paperwork for me, write a letter, do an evaluation, copy my chart, etc. I will give at least one week’s notice, and I understand there will be a fee involved.
7. In the unlikely event that there is a lingering balance that goes unpaid, it may be turned over to a collection agency. If that happens, an additional 30% processing fee will be added to the balance.
8. I understand that my client records are privileged and confidential and that information about me can only be released with my written consent, except by court order and except for such limited and relevant information as might be required for purposes of billing or collection or as otherwise specified in the Health Insurance Portability and Accountability Act.
9. I understand that my counselor is legally required to inform an appropriate authority without my consent if information I provide leads the counselor to believe that there is abuse or harmful neglect of children, the elderly, the disabled, or mentally or legally incompetent individuals. Or if I make a direct threat to harm myself or others.
10. I understand that if my counselor receives a subpoena or court order arising from any legal action to which I am a party, an hourly rate of \$300. per hour will apply to all time spent in preparation, response, depositions, testimony, and being away from the office for any purpose relating to the legal action. A retainer will be required.
11. While psychotherapy may vastly improve the quality of your life, it is also an expensive process. The duration of therapy is affected by the nature of your concerns and what your goals are. It is very important that you feel that you are benefiting from treatment. If at any time you feel that you are not getting what you want or need out of therapy, I urge you to discuss this with me so that we can find a solution for your concerns.

I have read, understand, and accept the conditions above.

Client Signature

Date

CONSENT TO CONTACT REFERRAL SOURCE, IF A PROFESSIONAL SOURCE

Referral source: _____ Phone #: _____

Permission to contact the referral source to thank them for referral: Yes or No

I am primarily interested in (check one or more):

- | | |
|--------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Finding my personal direction | <input type="checkbox"/> Overcoming fear of conflict |
| <input type="checkbox"/> Building confidence, self-esteem | <input type="checkbox"/> Finding love |
| <input type="checkbox"/> Finding new friends | <input type="checkbox"/> Becoming more independent |
| <input type="checkbox"/> Improving intimacy/sex | <input type="checkbox"/> Finding a different job |
| <input type="checkbox"/> Overcoming grief | <input type="checkbox"/> Overcoming procrastination |
| <input type="checkbox"/> Overcoming anxiety | <input type="checkbox"/> Learning to deal with stress |
| <input type="checkbox"/> Overcoming anger | <input type="checkbox"/> Just getting professional support |
| <input type="checkbox"/> Understanding myself better | |
| <input type="checkbox"/> Making a decision about _____ | |
| <input type="checkbox"/> Overcoming addiction to _____ | |
| <input type="checkbox"/> Improving a relationship with _____ | |
| <input type="checkbox"/> Leaving a relationship with _____ | |
| <input type="checkbox"/> Other: _____ | |

Symptoms:

In the last month, have you felt any of these symptoms? Check if Yes.

- Disturbed/Trouble sleeping. If so, how many hours? _____
- Trouble falling asleep or staying asleep? _____
- Nightmares
- Disturbed/Trouble with appetite. If so, lost weight or gained? How much?

- Lack of energy
- Lack of motivation
- Feeling "blue" or "down" or sad
- Not wanting to do things you previously enjoyed
- Avoiding family or friends
- Crying
- Feeling fearful
- Panic attacks. If so, how often?

- Feeling guilty
- Felt like life wasn't worth living
- Had difficulty concentrating, e.g. When reading a newspaper or watching TV
- Felt very restless
- Felt subdued or slowed down