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 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 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

OFFICE OF DEBBIE GRANOVSKY, LCSW

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

___Finding my personal direction
___Building confidence, self-esteem
___Finding new friends
___Improving intimacy/sex
___Overcoming grief
___Overcoming anxiety
___Overcoming anger
___Understanding myself better
___Making a decision about _____
___Overcoming addiction to _____
___Improving a relationship with _____
___Leaving a relationship with _____
___Other: _____

___Overcoming fear of conflict
___Finding love
___Becoming more independent
___Finding a different job
___Overcoming procrastination
___Learning to deal with stress
___Just getting professional support

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