Center for Change

Psychotherapy Services by Barb O'Brien, M.Ed., LICSW

INITIAL INTERVIEW FORM

Date:_____

CLIENT INFORMATION:

Name: _____
Phone: (Hm)_____(Wk)_____(Cell) _____
Address: _____
City: _____ State: _____ Zip: _____

Sex: Male _____ Female _____ Date of Birth: _____

Email: _____

Others living at home: _____

May I have permission to mail to this address? Yes _____ No _____

Primary Physician: _____ Phone _____

List any significant health problems: _____
_____
_____

List any medications you are taking and the dosage:_____
_____

Any previous psychological therapy? Yes _____ No _____ if yes, when and where?
_____

How did you hear about us? _____
Who may we thank for referring you? _____

Emergency contact? _____

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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 anytime.

FINANCIAL AGREEMENT AND AGREEMENT:

Payment is due at the time of service. Intake is $175. Individual counseling is $150/hr, couples counseling is $150/hr and support group is $45/wk. Family of origin group is $75/wk.

I accept Medica, UBH, BCBS, Aetna and Preferred One Insurance. If you have other insurance which provides coverage for this treatment, I would be happy to assist you in completing your claim forms or in filing your Out of Network claim for you.

******YOUR PAYMENT OR COPAY IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION. FEES ARE SUBJECT TO CHANGE EVERY SIX MONTHS.**

NO-SHOW AND CANCELLATION POLICY:

Your appointment time has been reserved for you. 24-hour notification of appointment cancellation is required. You may leave a message at any time on my confidential voicemail. Please note that you will be charged at regular rates if notification is not received, unless it is agreed upon that the absence was due to circumstances beyond your control.

STATEMENT OF UNDERSTANDING:

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

_____ _____

Client Date

_____ _____

Provider Date

CONSENT TO RELEASE/EXCHANGE INFORMATION:

I authorize any release of information as required by my insurance company to process my claim. I permit a copy of this authorization to be used in place of the original. This information may include: Place of service, diagnosis, type of treatment, medical background and relevant history, and information about treatment.

I authorize Center for Change be paid directly by my insurance carrier.

I authorize Center for Change to release billing information or date of service to the following individuals (list of names of any individual other than your self who may be allowed to receive this information, such as spouse): _____
_____

BILLING POLICY:

COPAYMENTS ARE DUE AT TIME OF SERVICE.

SIGNATURE: _____ DATE: _____