date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____

OK to leave texts: yes____ no_____ ok to leave voice mail: yes___ no____

Email Address: _____ Date of Birth: _____

Pronouns: ____ she/her/hers ____ he/him/his ____ they/them/theirs ___ Ze/Zir

Referred by: _____

Emergency Contact (optional): _____

Marital Status: ____ Single ____ Married ____ Domestic Partner ____ Divorced _____ Widowed

Employed by: _____ Occupation: _____

PT? FT? Student?

Person Responsible for Payment: _____Self _____Other
If other, please complete the following:

Name & relationship to you: _____

Address: _____City, State:_____

Zip Code: _____ Date of Birth: _____ Phone #: _____

assignment and release:
I certify that I &/or my dependent have insurance coverage and assign directly to Nancy Gardner, LCSW, all benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance as described on the reverse side. I authorize Nancy Gardner, LCSW to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship to Client | Date

I value the opportunity to enter into a therapeutic relationship with you, and I am committed to making sure that you are highly satisfied with the experience. My goal is to work with you to focus on the issues that you have identified-- whether these issues are avenues or obstacles to the life you want to live. I welcome feedback from you throughout the time we work together regarding interventions that are helpful, as well as interventions that are less helpful. I hope you will take advantage of that invitation and keep me informed.

The following are some agreements and authorizations as we get started. If you need clarification about any of these points, please let me know.

- You are responsible for payment at the time of service.

- If you are a Blue Cross/Blue Shield PPO member and you have met your deductible, you will only be responsible for your copay.

- If you are not a Blue Cross/Blue Shield PPO member, and you have another PPO insurance carrier, you are responsible for all fees. I will provide you with a monthly statement which you can submit to your insurance company in order for them to reimburse you for out-of-network coverage.

- You will be charged for any services which your insurance does not cover, including but not limited to phone sessions, court appearances, some meetings, school and agency staffings, and written reports.

- Cancellations need to be made at least 48 hours in advance. If you do not cancel your scheduled appointment at least 24 hours in advance, you will be charged a cancellation fee of $115.

- Failure to pay in a timely manner may result in termination of services, accrued interest, and other penalties.

_____ _____

Signature Date Witness Date