A. Rachel Weiss, MSW, LCSW

PSYCHOTHERAPY | TRAUMA RECOVERY | EMDR & SENSORIMOTOR

Client Registration (General Information)

Client name _____DOB: _____Age: _____Today's date: _____

Marital Status: S M D W Other_____

Current status: __Student ___Employed ___Unemployed ___Homemaker ___Retired ___ Other: _____

If student, Full Time or Part Time? FT PT School attended/ Area of study_____

If employed, Full Time or Part Time? FT PT Occupation/ Place of Employment _____

Emergency contact _____ Relationship_____

Emergency contact Phone Number _____Alternative Phone Number _____

If person filling out form is not client, check here: ____ What is your relationship to client? _____

Address & Contact Information

Home Address_____ Apt/ Suite_____

City_____ State_____ Zip_____

Home phone _____ OK to call? Y N OK to leave message? Y N OK to Text? Y N

Cell phone _____ OK to call? Y N OK to leave message? Y N OK to Text? Y N

Work phone _____ OK to call? Y N OK to leave message? Y N OK to Text? Y N

E-Mail: _____ OK to use? Y N (appointment-reminders will be e-mailed, you may opt out)

Preferred phone? ___cell ___home ___work Preferred method/s of communication? ___voicemail ____text ____call ____email

Any special instructions when calling/texting/emailing? _____

Insurance Information (complete ONLY if you will be seeking insurance reimbursement for your sessions)

Insurance company (e.g.: BCBS, Tricare, Medcost, etc.): _____

Name of employer providing insurance (if any) _____

Policy number _____ Group number _____

Policy holder name _____ Policy holder DOB _____

Insurance company address (see back of card) _____

_____City_____State _____ Zip _____

Insurance company phone/ Mental Health: _____ Provider Phone: _____

Note: Check with Rachel to see if she is "in network" with your insurance company. If out of network, you will most likely be required to cover the full session fee. Please check with your insurer to understand if you have a deductible for your coverage. Rachel and her Billing Specialist (Renee Bentley), will complete and submit all appropriate paperwork for you. Rachel's full Legal Name, when calling your insurance company, is "Alison Rachel Weiss, LCSW."

PLEASE TURN SHEET OVER FOR IMPORTANT INFORMATION & SIGNATURES

Initials and Signatures

_____ I understand it is my responsibility to pay for the session at the time of service. It is also my responsibility to pay $100.00 for cancellations with less than 24 hours' notice. (1st one is $50.00). For *any* No-Shows I understand that it is my responsibility to pay $130.00. (Price varies when not a 50-60 minute Individual Therapy Session- expect to pay the full cost of the session.)

_____I understand that in order to be in treatment with Rachel Weiss I must agree to leave a credit card on file.

_____ I affirm that I have willingly sought treatment from Rachel Weiss for issues relating to the field of mental health. I recognize that such treatment may involve exploration of my personal and family experience and has the potential to be emotionally unsettling. I agree and consent to receive treatment from Rachel Weiss at this time. I understand that I have the right to terminate such treatment at any time.

_____ I acknowledge that I have received, read, signed and consent to abide by the Client Rights and Responsibilities document.

_____ I acknowledge that I have read and consent to the Notice of Privacy Practices document, which explains in detail my rights to access my Personal Health Information (PHI) and how, when, and with whom, that information may be shared.

_____ I acknowledge that if Rachel Weiss deems the treatment I require to be beyond her level of training or resources as a solo practitioner that it is her ethical duty to provide referrals to other professionals or agencies. In the event that such referrals are, in her professional opinion, necessary for treatment to be effective, I recognize that in order to continue in therapy with Rachel Weiss I will need to follow up on such referrals and/or obtain additional licensed clinical responsibility for my care. Such situations may include (but are not limited to): recurrent suicidality, homocidality, alcohol or chemical dependency, eating disorders, domestic violence, symptoms of bipolar, and psychosis.

_____ I agree that Rachel Weiss's sole responsibility is in working with me as a therapist and that I will not enlist her in any legal proceedings related to my case. I further agree that neither her records nor her testimony will be subpoenaed for deposition or court testimony, and she will be exempt from conversations with social service personnel, parenting consultants, attorneys and members of the justice system.

Client Name (please print legibly) _____

Client Signature _____ Date _____