

INFORMED CONSENT TO TREATMENT

CONFIDENTIALITY STATEMENT

I understand and agree to the following:

- ❖ that treatment offered by Eugene Kayser, LMFT, is voluntary in nature, unless I am under the age of 18.
- ❖ that, within certain limits, information that may be revealed during therapy will be kept strictly confidential, requiring a written authorization from all parties in treatment if any information is to be released to any outside parties, with the exception of my insurance company.
- ❖ that if I reveal information indicating that I may be a threat either to myself or others, my therapist may be permitted and/or mandated by law to reveal this information to other persons or agencies for the safety of myself or others. This would include instances of suspected child abuse when treating a child under 18 years of age.

FINANCIAL AGREEMENT - The fee per visit is **\$120**, or the designated Co-Pay of \$_____, payable at the time of treatment. Please contact your insurance company to find out the amount of your co-pay.

FINANCIAL POLICY – Relationship issues, such as marital problems, are generally **not** covered by insurance companies. You are responsible for payment of this service, and may be able to get reimbursement. If you have a mental health diagnosis and your insurance company provides coverage for this provider, we will submit your claims forms. We will gladly discuss your proposed treatment if your insurance company calls us and you provide us with a release. You are responsible for the full fee regardless of your insurance company's reimbursement policies. Your regular fee will be charged for any additional professional services rendered by your provider at your request, such as phone contacts, preparation of forms and reports, court time, consults with other professionals, etc.

PAYMENT IS DUE IN FULL AT THE BEGINNING OF EACH SESSION.
FEES ARE SUBJECT TO CHANGE EVERY SIX MONTHS.

NO-SHOW AND CANCELLATION POLICY - Your visit has been reserved for you. **24 hours notice** is required for cancellation or you will be charged a late **cancellation fee of \$60.00.**

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

SIGNATURE _____

SIGNATURE _____

PARENT'S NAME (If client under 18): _____

PARENT'S SIGNATURE _____

THERAPIST'S NAME: _____ EUGENE KAYSER LMFT _____

THERAPIST'S SIGNATURE _____ DATE _____

INITIAL INTERVIEW FORM

Date: _____

CLIENT INFORMATION: *(Please print)*

Name of Insured: _____

Client's Name (if different): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Hm): _____ (Wk): _____ (Cell): _____

E-mail address to receive newsletter: _____

Soc. Sec. No. of Insured: _____ Of Client (if different): _____

Insured's Date of Birth: _____ Client's DOB (if different) _____

Gender: Male _____ Female: _____ Single _____ Married _____ Divorced _____

Insurance Carrier (if applicable): _____

Member No.: _____ Group No.: _____

Employer: _____ Occupation: _____

How long have you worked there? _____ How long in this occupation? _____

Others living at home: _____

Education: (List highest level attained) _____

Primary Physician: _____ Phone: _____

Psychiatrist (if any): _____ Phone: _____

List any medications you are taking and the dosage: _____

List any significant health problems: _____

Have you seen a therapist before? YES _____ NO _____

If so, when & with whom? _____

Give a brief description of treatment: _____

How were you referred to our office? _____

Who may we thank for referring you? _____

Emergency Contact: _____ Phone: _____

Entered _____