Bobette Siegel, MSW, LCSW
New Patient Information Form

***Personal Information (required)***

Name: _____ I Prefer To Be Called: _____
First MI Last

Home Address:

_____
Street City State Zip

**Email Address:** _____ **Home Phone #:** (___)_____

**Work #:** (___)_____ **Cell/Pager #:** (___)_____ **FAX #:** (___)_____

**Social Security #:** _____ **Birth date:** ____/____/____ **Age:** _____

**Driver License #:** _____ **State of Issue:** _____

**Gender (circle one):** Male Female

**Current Employer:** _____ **Occupation:** _____ **How Long Employed?:** _____

**Employer Address:**

_____
Street City State Zip

***Primary Insurance Information (required)***

**Insurance Company Name:** _____ **Phone #:** (___)_____

**Subscriber ID#**_____ **Group Policy #:** _____

**Policy Holder's Name:** _____ **Policy Holder's Phone#:** (___)_____

**Policy Holder's Address:**

_____
Street City State Zip

**Policy Holder's Employer:** _____**Policy Holder's Birth date:** ___/___/___ **Relation:** _____

**Copay Amount(per session):** _____ **Deductible Amount (if applicable):**_____

**Number of Sessions Authorized:** _____ **Authorization Number (if applicable):** _____

**Insurance Company Address (claims):**

_____
Street City State Zip

Bobette S. Siegel LCSW
14362 N Frank Lloyd Wright Blvd
Suite 1000
Scottsdale, AZ 85260
480.948.6222 (phone)
480.219.9970 (fax)

## Initial Information Form

Name: _____ Date: _____

Address: _____

Street City State Zip

Home Phone (___) _____ Social Security #: _____

Birth Date:____/____/___ Marital Status: M W S D Gender: M F

Employer: _____ Occupation/School: _____

Work Phone: (___) _____ Cell Phone: (___) _____

May I contact you: At Home? Yes No At Work: Yes No By Mail? Yes No

Name of Parent/Spouse/Guardian: _____
(Circle P/S or G Appropriately)

Name of Insurance: _____ Authorization Number: _____

Name of Insured: _____ Relationship: _____

Insured Date of Birth: _____ Insured SS#: _____

Group and/or Policy Number: _____ Emergency Contact: _____

Emergency Phone: _____ Relation to Client: _____

Referred By: _____

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What concerns bring you to counseling?

History of present issues:

What have you tried on your own to solve your concerns?

Family History (psychiatric, drug/alcohol):

History of own substance abuse:

## Household Members

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Medical History

Currently under doctor's care? Yes No Date of last physical exam? _____

Doctor's involved in your care? _____

Name of your primary care physician? _____

Health problems (including allergies) and surgeries with dates: _____

Medication currently using: (if none, state none)

| Medication | Dosage | Doctor Prescribing | Reason Prescribed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Person completing this form:

_____

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Fax: (480) 219-9970

## Statement of Understanding

This statement contains information about my philosophy of therapy and business policies. Please read it carefully and discuss any questions that might help to make your therapy experience as satisfying as possible.

**Philosophy:** I believe that therapy is a co-creative process in which the client(s) and therapist work together to define goals, assess progress, plan termination and provide referrals. I enter into this process with respect for individuals and have expectations of the same in return. The therapeutic process has challenges and benefits. As part of the process, you may experience unexpected and uncomfortable feelings, however, the benefits of therapy can include significant reduction in feelings of distress, improved relationships with others, and resolution of specific problems. Although therapy typically has a positive outcome, there are no guarantees and each individual is unique. Together, we will develop an individual treatment plan that outlines the major issues you wish to address and the approach that will be used to reach these goals. When you have reached these goals, I ask that you participate in a closing session to review your accomplishments and allow me to assist you in identifying any supports available to help maintain your growth.

I encourage you to discuss any questions you have about our relationship since the success of the therapeutic process requires a "good fit" between the therapist and client.

**Appointments:** Our sessions are typically 50 minutes in length. If you are unable to attend a session within 24 hours of the appointment time, please cancel and I will do the same. Failure to do so without good cause will make it necessary for you to pay for the missed appointment at your next scheduled appointment. Insurance does not cover missed appointments. This therapist has the option of not scheduling/providing the session if you are not current with payments.

You can leave all messages on my confidential voice mail. I retrieve these messages periodically throughout the workday. If the message is urgent, please indicate so. In the event of a life-threatening emergency, please call 911 or these other agencies: EMPACT/Suicide Crisis Hotline (480) 784-1500; TERROS (602) 685-6000; Child Protective Services (888) 767-2445; Crisis Intervention (800) 631-1314; or National Domestic Violence Hotline (800) 799-7233.

**Fees**: The cost of service is your responsibility. Payment is expected at the time of service.

Checks returned for insufficient funds will be charged an additional $35.00.

Administrative charges will be applied when you request information to be sent or reviewed. It is your responsibility to verify these charges at the time of your request.

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## Statement of Client's Rights

**You have the right:**

1. To confidentiality and you, the client hold the legal privilege to all information presented during therapy. Without written consent, information will not be released to anyone. This confidentiality is protected by law. There are, however, exceptions to this privilege if:

    A. You give written consent.
    B. Disclosure is required by law.
    C. You file a benefit claim and the claim payer requires information.
    D. The client is a danger to self or others (i.e., threatens grave bodily harm, discusses plans to terminate his/her own life or makes a threat against any individual). The warning communication will be limited to those individuals who absolutely need to know and designed to provide only information necessary to protect the potential victim.
    E. The client describes a situation in which the professional therapist has reason to suspect child abuse or neglect, sexual abuse or abuse of a senior citizen (i.e. parent). There may be other situations prescribed by law in which confidentiality is waived. If confidentiality is waived, the therapist may warn a potential victim and inform the local authorities.

2. To an established set of treatment goals to be reviewed and evaluated regularly.
3. To participate in decisions involving your individual treatment.
4. To ask questions about any techniques or therapeutic procedures and to be informed of any potential risks involved with treatment.
5. To participate or not participate in scientific research.
6. To have reasonable access to medical services and information about charges for which you will be responsible.
7. To terminate treatment at any time without moral or legal obligations. Should you require the names of other qualified therapists, they will be furnished.

## Statement of Client's Responsibilities

**You have the responsibility:**

1. To support the patient-provider relationship. For example, please exercise courtesy and make every effort to keep scheduled appointments.
2. To present true and accurate information.
3. To comply with recommendations of the clinical treatment program.
4. To avoid actions or threats that endanger the lives, health, or social well-being of my employees, myself, or other patients.
5. To pay any necessary fees at the time of the appointment.
6. To not engage in illegal acts, such as forging or falsifying providers' name on documents requiring provider's signature.
7. To notify the provider if you should decide to discontinue treatment.

I have read and understand the above:

_____

Signature-Patient or Parent/Guardian Date

BALANCES SIXTY (60) DAYS PAST DUE WILL BE SUBJECT TO A 15% INTEREST CHARGE PER MONTH ON THE UNPAID BALANCE. UNPAID BALANCES OVER (90) DAYS WILL BE REFERRED TO THE CREDIT BUREAU.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO THERAPIST:

I hereby authorize payment of all benefits to Bobette S. Siegel, M.S.W., A.C.S.W., L.C.S.W., otherwise payable to me, relative to the services reported. I understand that I am financially responsible for the charges not covered by this authorization.

I understand that by signing below I waive my right to confidentiality in the collection of any fees in dispute for services rendered.

I have read and understood my responsibilities regarding fees, payment, no shows, collection procedures and costs. I give consent to the provider to begin treatment as discussed.

_____

Signature-Client or Parent/Guardian Date

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS IMPORTANT INFORMATION. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.

Copy to client: _____

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**I have read and acknowledge receipt of this HIPAA notice**

Patient Name: _____ Date: _____

Signature: _____

Parent if applicable

Signature: _____