

Suzanne R. Benko, MFT, APC

CLIENT INFORMATION

Date _____ Referred By: _____

Patient Information

Name _____ Gender _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ May I leave a message? _____

Cell Phone _____ Which is your preferred contact? _____

Email Address _____

Date of Birth _____ Social Security # _____

Relationship Status (If under 18 years old, include this information on your parents)

Spouse/Partner/Parent Name(s) _____

Married _____ Committed Relationship _____ How Long? _____ Living Together _____

Single _____ Separated _____ Divorced _____ Widowed _____

Children/Siblings

1. _____ age _____ 4. _____ age _____
name name

2. _____ age _____ 5. _____ age _____
name name

3. _____ age _____ 6. _____ age _____
name name

Anyone else living in the home?

Name _____ Relationship _____

Is someone other than patient responsible for this account? No _____ Yes _____

If so, please complete the following:

Name _____ Phone _____

Address _____

Emergency Contact

Name _____ Relationship _____

Phone _____

Previous mental health treatment:

Counseling/therapy () yes () no Approx. date _____

Name of therapist(s) _____

Reason for treatment _____

Psychiatric medications _____

Substance abuse treatment? _____

Family history of substance abuse or psychiatric problems _____

Please give a brief statement of current problems and reasons which bring you to therapy at this time.

Education/Employment

If you are currently attending school:

Name of school _____

Grade _____ Approximate GPA _____

If you have completed school:

What was your highest grade or degree you achieved? _____

Employed by _____ How long? _____

Title/Position _____

Confidentiality

All personal information is confidential, including the fact that you are a client here. We conform to federal and state laws regarding therapist/client confidentiality. No records of information will be shared with anyone without your expressed written permission to do so. Exceptions to this policy as we are mandated by law to report include the following:

1. If you threaten grave bodily harm or death to another person or yourself;
2. If a court of law issues a legitimate subpoena;
3. If child abuse, sexual abuse, or child neglect is suspected;
4. If physical abuse is suspected with a person 65 years or older;
5. If physical injury, abuse and/or assaultive behavior toward a spouse is suspected.

Financial Agreement

Each of our sessions is scheduled to last fifty (50) minutes. You will not be charged for a session if you cancel your appointment at least twenty-four (24) hours in advance. IF YOU FAIL TO KEEP AN APPOINTMENT OR DO NOT CANCEL WITHIN TWENTY-FOUR (24) HOURS OF THE SCHEDULED APPOINTMENT TIME, YOU WILL BE CHARGED THE FULL SESSION FEE.

I am available to return calls during the day and evening hours. However, in case of an emergency after those hours, you are asked to call 911 if you need immediate attention. If telephone contact is required frequently or for extended periods of time, you may be charged a full session fee.

IT IS CUSTOMARY TO PAY FOR SERVICES AT THE TIME OF EACH SESSION. Payment for services can be made by cash, check, or credit card (VISA or MasterCard). Medical insurance billing is provided by my office as a courtesy only. YOU ARE RESPONSIBLE FOR YOUR ACCOUNT. If payment in full is not possible at the time of service, please discuss arrangements for payment BEFORE your session.

Although I will file insurance claims on your behalf with your insurance carrier, it is important for you to remember that YOU CARRY THE INSURANCE COVERAGE AND PAYMENT FOR SERVICES IS ULTIMATELY YOUR RESPONSIBILITY. If services were rendered to you, then you are responsible for payment of your account regardless of the amount your insurance covers. If your account becomes delinquent, you may be responsible for reasonable attorney’s fees, court costs, collection agency costs, and interest at 1.5% per month. For accounts that are past due and delinquent over 90 days, a \$25 monthly late fee will be applied to the outstanding balance on each monthly billing cycle.

FEE SCHEDULE:

New Outpatient Assessment and Evaluation	175.00
Individual/Family/Couple Therapy	150.00
Group Therapy (90 minutes)	75.00
Hospital Individual/Family Therapy	200.00
Forms, letters, reports (prorated 50 minutes)	150.00

I, the undersigned, have read this letter of financial agreement and agree to its terms and conditions.

Client Date

Client Date

Therapist Date

CREDIT CARD INFORMATION AND AUTHORIZATION
(To be completed even if sessions are to be paid by cash, check, or insurance)

I hereby authorize Suzanne R. Benko, MFT, APC to charge my counseling session fees to the account shown below. I understand that I will be charged the full session fee if I do not cancel within twenty-four (24) hours of the scheduled appointment time.

____ VISA

____ MASTERCARD

Name on Card _____ Billing Address Zip Code _____

Account Number _____

Expiration Date _____ V Code _____ (3 digit code on back of card)

Cardholder Signature _____