Deborah Meints-Pierson
CONFIDENTIAL CLIENT INFORMATION

Name _____ DOB _____

Age _____ SSN# _____ Gender: M____ F ____

Address _____

City _____ State _____ Zip _____

Home Phone _____ OK to leave message? Yes No

Work Phone _____ OK to leave message? Yes No

Cell Phone _____ OK to leave message? Yes No

OK to text message to cell phone? Yes No

Marital Status _____

Email Address _____

OK to contact through email? Yes No

Referred by _____

Children:

Name	Age
_____	_____
_____	_____
_____	_____

Employment Status _____ Occupation _____

Family Monthly Income _____ Ethnic Origin _____

Religious/Spiritual Orientation _____

***CANCELLATIONS:** If an appointment is cancelled with **less than 24 hours notice, you will be charged** for that session. The only exceptions to this rule are emergencies. Rescheduling should take place at the time of cancellation. PLEASE INITIAL HERE _____

IN CASE OF EMERGENCY, NOTIFY:

Name _____ Relationship _____

Address _____ Phone # _____

CONFIDENTIALITY: Information between counselor and client is held strictly confidential unless 1) the client authorized release of information with a signature; 2) the counselor is ordered by a judge to release information; 3) a client presents a physical danger to self or others; 4) child abuse/neglect are suspected 5) group therapy involves disclosures among group members.

_____ _____

CLIENT SIGNATURE **DATE**

Deborah Meints-Pierson

REASON WHY YOU ARE HERE

_____Marital _____ Parenting _____ Addiction _____ Violence _____Occupation

_____ Family _____ Anger _____ Other

MEDICAL INFORMATION

1. List any medical and/or psycholgical issues (i.e., diabetes, depression)

_____

_____

_____

2. List all current medications

Name	Dosage	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Please list any and all psychiatric hospitalizations and chemical dependency treatments

_____

_____

ALCOHOL AND OTHER CHEMICAL USE

Have you ever abused any of the following drugs:

	Yes	No		Yes	No
Alcohol	___	___	Pain Medication	___	___
Caffeine	___	___	Marijuana	___	___
Tobacco	___	___	PCP/LSD	___	___
Tranquilizers	___	___	Heroin/Methadone	___	___
Barbiturates	___	___	Inhalants, glue, etc.	___	___
Amphetamines/Speed	___	___	IV drug use	___	___
Sleeping Pills	___	___	Designer drug use*	___	___

* Exstasy, GHB, Ketamine

Are you in recovery and for how long? _____

Additional information that you think is important for understanding your situation

_____

_____

_____ _____

CLIENT SIGNATURE **DATE**

Deborah Meints-Pierson

THERAPY PARTNER
ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard and Discover. Service fees will be deducted from the designated account at the time services are rendered.

Client information

Client Name _____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Home Telephone # _____ Cell # _____ SSN _____

Email: _____

Billing Information

Please indicate the information associated with the credit card you wish to use

Name _____

Address _____ City _____ State ____ Zip _____

Email _____

I authorize all service fees to be deducted from the card ending in _____ (last 4 digits of card)

Please enter CVV code _____ (last three digits on back of card)

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

CARDHOLDER SIGNATURE **DATE**

Payments are processed by Therapy Partner
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY

Credit Card Information

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one) Visa MasterCard

Card Number: _____ Expiration Date: _____