Hello.
PLEASE COMPLETE ~
~Name

~Address

~City, zip code

~email address

Email correspondence is not considered confidential. I only use it for scheduling.

~May I email you? Please circle yes or no.

~Home/ Cell telephone

~May I leave a message?
Please circle yes or no.

~Work telephone

~May I leave a message?
Please circle yes or no.

~Date of birth

~Marital status

~Name of spouse/spouse equivalent

~Spouse/ equivalent work telephone

~Employer's name and address

~Children, name[s] and age[s]

~Referred by, name and address

~Do you give permission for me to contact this person to thank them for referring you? Please circle yes or no.

~Person to contact in an emergency
~Name

~Telephone

~Person responsible for the bill
~Name

~Address

~Telephone

~Relationship to you

PLEASE READ ~

I make every effort to honor all time commitments and request that you extend the same courtesy to me. Please notify me of a cancellation, AT LEAST 48 HOURS IN ADVANCE, Monday through Friday. My policy is to charge for late cancellations and nonappearance regardless of the reason. Please note this policy. Payment is due at each visit.

In the unexpected situation where you have not paid your bill and after contacting you about alternative arrangements, your outstanding invoice will be sent to collections; you will be charged for the costs to collect those fees.

~Would like a copy of this agreement? Please circle yes or no.

~Signature

~Date

continue, please . . .

Therapy is a joint effort. The results cannot be guaranteed. Progress depends on many factors.

In connection with the treatment with Bonnie L. Bernell, Ed.D., and after discussing these matters with her, I hereby consent to the following [please circle "yes" or "no" on each item]:

1. yes / no
I acknowledge that I have been told that:
a. if a client expresses to a therapist a serious threat to harm an identifiable person, the therapist must warn that person and the police;
b. if the therapist suspects child abuse or neglect, elder abuse or dependent adult abuse, a report must be made to a child protective agency or other designated protective agency;
c. if a client is dangerous to him/herself or others or unable to care for him/herself, then hospitalization may be requested;
&, d. confidential information or records would have to be disclosed in the event of a court order.

2. yes / no I understand that information, records, or testimony about me may have to be produced in limited circumstances without my specific consent.

3. yes / no I understand that I may withdraw from treatment at any time.

4. yes / no My consent is voluntary and except for number 1 above and urgent consultations, I may withdraw my consent to future disclosure at any time by writing a letter to Bonnie L. Bernell, Ed.D. yes / no
5. I request a copy of this form by circling yes.
6. yes / no
I acknowledge that I have been told that Bonnie L. Bernell, Ed.D. is not now, and has never been, a Medicare provider. Appropriate treatment may be available at a lower out of pocket cost from a Medicare provider. You can obtain a list of such providers from Medicare. With respect to receipts I receive from Dr. Bernell, I shall not submit any reimbursement requests to Medicare.

signature:
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date: _____.

signature:
---

date: _____.

To consider . . .
What are your strengths?

What would you like to accomplish in therapy?

THANK YOU.