Claudia Franzosi, MFT
Individual and Family Therapy
615 East Lexington Ave., El Cajon CA 92020 Phone: 619-246-6700
www.sandiegotherapynow.com

This information is kept strictly confidential. Please print and bring to your first visit.

Patient's Name_____ Date Of Birth_____
Social Security #:_____Sex: M__F__ Ethnicity_____
Address_____Apt #_____
City_____Zip Code_____

Home Phone Number:_____OK to call?___OK to leave message?__
Work Phone Number:_____ OK to call?___OK to leave message?__
Cell Phone Number:_____ OK to call?___OK to leave message?__
Other Phone Number:_____ OK to call?___OK to leave message?__
Emergency Contact Person:_____Phone #:_____

Email address:_____
(please rest assured that your email will never be sold, and that you will not be spammed):
OK to send an email if I cannot reach you by phone? Yes__ No__
OK to inform you of occasional workshops/programs specific to your situation? Yes__ No__

Presently lives with:

Relationship to patient	Name	Birth Date	Social Security Number (only if spouse or parent of patient)

Primary Insurance Co:_____ID#_____
Group_____Primary Insured's Date of Birth_____
Primary Insured's Name (exactly as it appears on insurance card)_____
Primary Insured's Employer_____Primary Insured's Social Security #_____

Currently in a relationship?_____How long?_____How happy?_____
Last Grade Completed:____Name of School Attended (if child):_____
Type of work:_____How satisfied at work?_____
Medical Conditions:_____
Medicines used (dosage and for what): _____
_____
Alcohol or drugs used (type, amount, and how often): _____
_____
Sleeping problems:_____ Eating problems: _____
Suicidal thoughts (explain)?_____
Thoughts of hurting others (explain)?_____
Briefly explain why you are here: _____
_____
_____
_____
_____
_____

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WELCOME!
What you reveal in therapy is confidential. At the very beginning of treatment, we will clarify what is kept confidential or what is shared. There are some exceptions to confidentiality:

If you give permission or make a signed request, or communicate your serious intent to hurt yourself or someone else, in situations of child or elder abuse, or abuse of a dependent person, and in some legal situations such as by Court order.

If I bill your Health Insurance or a third party for you, I must provide some information, usually including your diagnosis, fee, dates of services, and sometimes a treatment plan.

PAYMENT:
My fee is $150.00 for a 45-50 minutes individual or family session. Payment and co-payments are expected at the time of services in *cash or check*. No credit/debit cards are accepted. As a courtesy to you, if a third party or insurance pay for the sessions, services will be billed directly to the third party. You are financially responsible for all charges not covered by your insurance or other third party.

On our initial contact I advised you to ask your insurance if you need an pre-authorization, what is your co-payment and deductible, and how many sessions you have per year. Please double check with your insurance if you are not sure. It is your responsibility to get that information or authorization before we begin. **If you do not have that information at your first session, please come prepared to pay my full fee in cash or check at your first visit.** You state that you are responsible for a co-payment of $_____. If your insurance shows a different co-payment amount or a deductible, you are responsible for the amount stated by your insurance.

Please inform me of any changes in your insurance status. If your insurance coverage is discontinued and you promptly inform me, we will try to arrange a payment method that works for you or a sliding scale fee. If you request a letter/report, you will be charged at $ 150.00 per hour, with a minimum charge of $ 100.00.

ATTENDANCE AND CANCELLATIONS:
Regular attendance to therapy is important for your progress. You agree to keep each scheduled appointment unless you have a serious emergency or illness. Please do not make other plans if we have an appointment. If you cancel for reasons other than serious emergencies, you may not be able to continue here. No-shows, forgetting appointments, or missing more than one session in four months may result in your time not being available to you anymore or a referral to other therapists. **If you are unable to keep an appointment, a minimum of 24 hours advance notice is required. If your appointment is on a Monday, you need to cancel the Friday prior to that before 5:00PM. If you do not cancel your appointment within this timeframe, you will be billed $ 50.00.** You agree that you are personally responsible for paying a late cancellation/no-show fee. Third party payers and insurances cannot be billed for the missed session. The responsible party for bringing the client and signing below is therefore responsible for the payment of the missed session. This includes foster parents and other family members.

_____ _____

_____ _____
(Please sign here to express consent to this) Date

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If you are paying by a personal check, you will be assessed a $ 25.00 fee if your check is dishonored or not cashable. If you are making a partial payment, you agree to pay in full before the next scheduled session. Therapy can be terminated for non-payment of services. If you do not pay in full within 15 days of your debt and we have not arranged a payment plan, your bill could go into collection without further notice, and/or legal proceeding could be started. This may affect your credit. Collection fees are separate and in addition to any amount due. The amount due will also incur a yearly 10% late fee if payments are not received on time.

EMERGENCIES AND PHONE CALLS:
You are free to leave a message in between sessions at 619-246-6700, but please know that your therapist is only available at your scheduled appointment time and does not provide free therapy over the phone. Also, please act responsibly and make a note of your appointment time, directions, and address: your therapist may take one business day or more to return your call, and does not make calls to remind you of your appointment. In case of mental health emergencies, please call the Crisis Line at 1-888-724-7240. This Line is accessible 24 hours a day, 7 days a week. For immediate danger, call 911 immediately.

TERMINATION:
Termination is an important part of therapy. At least a two-week notice is suggested so that termination can occur smoothly, and proper referrals and options can be identified and discussed.

"I have read and agreed to the above information. I authorize Claudia Franzosi, MFT, to release any medical or other information necessary to process my claims or collect late payments. I also request payment of government benefits either to myself or to my therapist who accepts assignments. I authorize payment of medical benefits directly to Claudia Franzosi, MFT."

If I speak a language different than English, I have been explained this form in its entirety and have had the opportunity to ask any question. _____

_____	_____	_____
Signature – Client (or Responsible Party if client is a minor)	Name (PLEASE PRINT)	Date
_____	_____	_____
Signature – Client (both partners sign for couples counseling)	Name (PLEASE PRINT)	Date

Please find us at:www.sandiegotherapynow.com