Initial Client Information

Date: ____________________ **Ref'd By** ______________________

First Name ______________________________________ **Last** ____

Date of Birth _______________________ **Email** ____

Hm Phone ___________________________ **Cell** ___________________________ **Wk** __________________________

Address, City, Zip ____

Current Relationship? ☐ Solo ☐ Dating ☐ Committed ☐ Married* ☐ Separated How many years? __________

Children? ____ *How long friends before marriage? _________

Type of Work or School? ____________________________________ **Spirituality?** ____________________________

Medical or Psychiatric Issues? Meds? ____

Consent to Treatment

I hereby consent to engage in a counseling relationship and treatment with Nate Havlick, LCSW. I understand that developing a treatment plan with specific goals and regularly reviewing our work toward meeting those goals is in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time, in which case my only responsibility will be to pay for those services already received.

I understand that all appoinment cancellations must be made at least 24 hours in advance - otherwise, I will be charged $50 for the appointment. This does not apply in the event of physical emergency (illness, flat tire, etc).

I am aware that my insurance company or other 3rd-party payer may be given information about the type, cost, and dates of services received - and that I am responsible for reimbursement should insurance fail to pay.

Notice of Privacy Practices

I hereby acknowledge that I have been given an opportunity to read a copy of Nate Havlick, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Mr. Havlick.

My signature below shows that I understand and agree with all of these statements.

_________________________________ ____ ____________________

Name Signature Date

Financial Agreement

** To be filled out with therapist at initial meeting **

______ **Insurance/EAP**: I hereby authorize Nate Havlick, LCSW to release medical or other information necessary to process my insurance claims. I agree to be responsible for all deductibles and co-pays, as well as the $50 late cancellation fee.

______ ***or* Private Fee**: I agree to pay $________ for ______ sessions beyond the initial consultation. I also accept responsibility for the $50 late cancellation fee as described above.

____ _____________________________

Signature Date

This is a confidential, privileged patient medical record. Redisclosure or transfer is expressly prohibited, except where provided by law.