Ellyn L. Turer, PsyD, PLLC
1320 19th Street, NW
Suite 202
Washington, DC 20036
Tel: 202-293-6463, ellyn-turer@hushmail.com

Date_____

CLIENT INFORMATION

Client Name _____

Address _____

City _____ State _____ Zip Code _____

Primary Contact Ph # _____ Cell Home Work

Secondary Ph # _____ Cell Home Work

Email Address _____ Do you text? Yes No

Birth date _____ Social Security Number _____

Occupation _____ Place of Employment _____

Education (Highest Grade Completed) _____ Marital Status _____

SPOUSE OR PARENT INFORMATION (If applicable)

Name _____

Address _____

City _____ State _____ Zip Code _____

Primary Contact Ph # _____ Cell Home Work

Birth date _____ Social Security Number _____

Occupation _____ Place of Employment _____

Education (Highest Grade Completed) _____ Marital Status _____

CHILDREN/SIBLINGS

Name	Birth date/Ages	Grade in School	Living at Home

Name of Emergency Contact _____ Relationship _____

Emergency Contact Ph # _____ Cell Home Work

Preferred way of confirming appointments: _____Home _____Cell _____ Text _____E-mail

Whom may we thank for referring you to us? _____

May we send a thank-you to the referral source? Yes _____ No _____

1. Briefly describe the problem for which you are seeking help.

2. How do you think we can best assist you?

3. Who is your personal physician/pediatrician? _____

4. When was your last physical examination? _____

5. Please describe any physical disabilities or health problems.

6. Please list any medications you are now taking:

7. Have you or your child received psychiatric help or psychological counseling before? (Circle) YES NO
   If yes, with whom and dates? _____

8. Have you previously, or are you currently, serving in the military? (Circle) YES NO
   If yes, list branch and dates of service _____

Please check any of the following symptoms/problems that pertain:

- ☐ Fears or phobias
- ☐ Shyness
- ☐ Having to do things over and over
- ☐ Intrusive thoughts
- ☐ Making decisions
- ☐ Need to be in control of everything
- ☐ Nightmares
- ☐ Relaxation
- ☐ Stress
- ☐ Coping with a traumatic event
- ☐ Unresolved grief
- ☐ Depression
- ☐ Unhappiness
- ☐ Inferiority Feelings
- ☐ Suicidal thoughts
- ☐ Lack of ambition
- ☐ Blocked emotions
- ☐ Tiredness
- ☐ "Up-and-down" feelings
- ☐ Lack of Energy
- ☐ Loss/Increased Appetite
- ☐ Sleep problems
- ☐ Concentration
- ☐ Procrastination
- ☐ Memory
- ☐ Relationship problems
- ☐ Loneliness
- ☐ Anger/Temper
- ☐ Frustration
- ☐ Self control
- ☐ Headaches
- ☐ Stomach Problems
- ☐ Bowel Problems
- ☐ Health Problems
- ☐ Weight
- ☐ Sexual Problems
- ☐ Alcohol or drug use
- ☐ Education
- ☐ Work
- ☐ Career choices
- ☐ Parents Separation/Divorce
- ☐ Legal Matters

Parenting Issues

- ☐ Discipline
- ☐ Divorce Issues
- ☐ Parenting Skills

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CONSENT FOR TREATMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I acknowledge that I have received, read, and understand the policies and procedures as described in the Client Information forms and do so indicate by affixing my initials next to each of the following points:

_____ 1) Confidentiality - I am aware that an authorized agent of my insurance carrier or other third party payer may request and be provided with information about the type(s), cost(s), and date(s) of any services or treatments I receive so that payment may be provided to my clinical psychologist.

_____ 2) Payment and Billing Policies - I am aware that I am responsible for payment in full for any charges for services provided on my behalf unless they are specific services provided under the benefit plans of my insurance and as designated in any contract between my clinical psychologist and my insurance company and its lawful delegates.

_____ 3) Financial Responsibility - I am aware that I may terminate treatment at any time without consequence, but that I will still be responsible for payment of the services I have received. I am aware that if I have not paid for services received, my treatment may be discontinued and my account turned over for collection.

_____ 4) Appointments and Cancellations - I am aware that any cancellations of appointments must be made at least *24 hours* in advance of the appointment and if I do not cancel or do not show up I will be charged for that appointment.

_____ 5) Intra-agency Consultation - I am aware that my clinical psychologist may consult or share information with other health care providers who are involved in my clinical care. I understand that I may sign an additional document to authorize this communication.

_____ 6) Risks of Psychotherapy - I am aware that the practice of psychotherapy is not an exact science and that predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the clinical psychologist identified below.

_____ 7) Court Testimony and Custody Evaluations – I am aware that clinical psychologists make every effort to maintain client confidentiality and therefore do not testify in court regarding custody, divorce action, or other legal matters. I agree not to contact my clinical psychologist personally or via my attorney to testify in court. If my clinical psychologist is contacted/subpoenaed on my behalf for testimony, I agree to pay all court costs, legal fees, and hourly rates for my clinical psychologist's time.

_____ 8) I do_____ do not _____ have questions about this consent for treatment/financial policy.

I do hereby seek and consent to participate in evaluation and or treatment with the clinical psychologist identified below.

_____
Client Signature Date

_____
Clinical psychologist Date

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Business Policies

Our experience has been that counseling and psychotherapy are most effective when expectations regarding fees, billing, insurance, reimbursement, and cancellation policies are understood by all parties in advance. Please review the information below, and feel free to ask if there are any questions.

GENERAL FEES

For individual, couples, and family therapy. Most sessions are 45 minutes in length. Longer or shorter sessions may be recommended in certain circumstances:

Intake individual session……$275.00
Individual 45 minute session……..$225.00
Intake family or couples session.……$300.00
Family or couples 45 minute session……..$275.00

Other fees may be charged for specific services, such as hospital visits, consultation with attorneys or other professionals, structured group programs focusing on a particular topic or problem, detailed psychological evaluations completed at the request of a physician or attorney, etc. We would be happy to discuss our fees for these services with you at any time.

In some situations, clients may be asked to complete psychological testing instruments. Fees for other tests will be communicated in advance and vary according to the nature of the test.

INSURANCE
Health plans vary widely in their mental health benefits, and most plans have both yearly and lifetime benefit limits. Further, many "managed care" plans periodically review your symptoms or progress in therapy and may markedly restrict the number of sessions authorized for insurance payment. **It is your responsibility to familiarize yourself with the authorization procedures, reimbursement rate, limitations, and specific provisions of your health policy, although we will be happy to help when we can if there are questions. Keep in mind that even if you have insurance, you are the one who is ultimately responsible for payment of your bill.** This is true even if the insurance company withdraws authorization for services after the services have been performed. We cannot take responsibility for negotiating settlements of any disputes with your insurance company.

PAYMENT
We can usually estimate fairly accurately the amount of our fee that will be covered by your insurance. Payment for the client responsibility portion of your bill (the "co-pay/co-insurance/deductible") is due at the time services are rendered. If this is not possible, discuss the situation with us to see if alternative arrangements can be made. In the event that you remit payment for your deductible at session and your deductible is met during our initial billing process, any resulting credit will remain on your account to be applied to your co-pay/co-insurance. Services may be discontinued if fees remain unpaid for an extended period of time. We reserve the right to retain a collection agency or attorney to collect unpaid fees after termination of therapy if the former client fails to make a reasonable effort to pay off any outstanding balance. Forms of payment accepted: cash, check, credit card, or wire transfer.

CANCELLATIONS AND MISSED APPOINTMENTS
If you cannot keep an appointment, please notify our office at least 48 hours in advance so that we can reschedule someone else for the time that has been reserved for you. Unless we are able to reschedule with shorter notice, **the regular fee may be charged for appointments missed without notice or canceled with less than 48 hour notice.** There is no charge for appointments canceled due to illness or emergency if the office is notified prior to the scheduled appointment time.

My signature below indicates that I have read, that I understand, and that I agree to the business policies outlined above. I agree to assume financial responsibility for the cost of services to me or to the person whose name appears below. I authorize Ellyn L Turer, PsyD, PLLC and its billing agency to act as my agent in helping me obtain payment from my insurance company (if applicable). I agree to the release of whatever information is necessary for the insurance company to process my claim. Unless I pay in full at the time of each session, I authorize my insurance company to pay benefits directly to Ellyn L Turer, PsyD, PLLC. I permit a photocopy of this authorization to be used in placed of the original.

Printed Name of Client: _____ Client Date of Birth:_____

Responsible Party if Client is a minor:_____SSN:_____

Signature of Adult Client or Responsible Party:_____

Date:_____Witness:_____