Confidential Client Information Form

Contact Information

Date:

Name:

Street Address:

City/State/Zip:

D.O.B./location of birth:

OK to call? ☐Yes ☐No

OK to leave message? ☐Yes ☐No

Home phone: ☐Yes ☐No

Cell phone: ☐Yes ☐No

Work phone: ☐Yes ☐No

OK to email? ☐Yes ☐No

Email:

Please provide a name and phone number of whom to call in case of an emergency:

310-279-8480

Jarrad@JarradMalamed.com

www.JarradMalamed.com

3547 Beethoven St. Los Angeles CA 90066

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Demographics

Your preferred Gender Pronoun(s):

Sexual Orientation(s):

Ethnicity:

Disability Status:

Partner(s)/relationship:

Occupation/Employer:

Health Information

Current reason(s) for seeking therapy:

Estimate the severity of the problem for which you are seeking care:

☐Mild ☐Moderate ☐Severe ☐Very Severe

How many sessions or how much time do you think you might need to successfully resolve this problem?

☐1 – 10 sessions ☐20 or more sessions

☐ 10 – 20 sessions ☐Longer-term therapy

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Have you ever been hospitalized? ☐Yes ☐No

Are you currently taking any medications? (Please list names, dosages, and prescribing doctor.):

Have you previously been in psychotherapy? ☐Yes ☐No

Please briefly describe your reason(s) for seeking treatment at this time:

Was there an event that made these issues or problems surface?

Do you have any specific goals for treatment? What result(s) do you expect from treatment?

Do you have any particular concerns/fears with regard to treatment?

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Have you had therapy before? If so, please tell me when, with whom and what worked or didn't work:

When were you last examined by a physician?

Outcome?

Referral Information

Who referred you to me or how did you hear of my practice?

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Informed Consent

Patient Name: _____
Today Date: _____

The following information is provided to you so that you have a better understanding of how your care will be provided. Should you have any questions or concerns about my policies, please ask me so that we can discuss them.

Confidentiality

All information between therapist and patient is held strictly confidential unless:
1. patient authorizes release of information with his/her signature.
2. patient presents a physical danger to self.
3. patient presents a danger to others.
4. child/elder abuse is suspected.
5. patient fails to pay for services rendered and formal collection becomes necessary.

I am required by law to inform potential victims and legal authorities so protective measures can be taken in the case of significant risks to others.

Financial

If you are a member of an insurance plan of which I am a covered provider, I will bill your insurance company directly and you will be responsible for any applicable **deductibles** and **copayments**. Deductibles frequently renew at the beginning of the calendar year, and you will be responsible for the full contracted fee until your deductible is met. I am happy to check your insurance benefits and provide you with details at any time. In addition, you can always call the member services number on your insurance card to verify. Please note that if your eligibility for benefits lapses, you will be responsible for full payment of my fee of $150 per session.

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Should I be required to testify or participate in any legal matter on your behalf, the fee for my time is three times my normal rate, or $495 per hour.

Copayments must be paid at the time services are rendered by cash, check or electronic payment transfer (Zelle, Venmo). If you wish, I can also keep a credit card on file, in which case I will bill on a monthly basis.

Canceled/Missed Appointments

You may cancel or reschedule an appointment at any point up to 24 hours prior to the scheduled appointment. A psychotherapy appointment means that time is reserved only for you. ***If an appointment is missed or canceled with less than 24 hours notice, you will automatically be billed a cancellation fee of $75 as insurance companies will not cover missed appointments***.

Urgent procedure

If you need to contact me urgently, call me cell phone (310)279-8480, leave a message if necessary, and your call will be returned, typically within the hour. If you experience a true life-threatening emergency and need immediate attention, you should call 911 or go to the nearest hospital emergency room, then leave a message for me at your earliest convenience.

Release of Information (insurance and other)

I authorize release of information regarding my care to my health plan for the payment of claims, certification/case management decisions and other purposes related to the administration of benefits for my Health Plan.

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Consent for Treatment

I further authorize and request that my treating provider carry out psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that, while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

Assignment of Benefits

I authorize payment of medical benefits directly to my therapist.

SIGNED _____
Date_____

I understand and agree to all of the above information.

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