Client Information Sheet

The information requested on this form is completely confidential.

Today's Date: _____, 201

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip+4: _____

Contact information: home_____ work _____
Please put a check next to
the best number to use mobile_____ e-mail _____

Is it okay to leave confidential messages at the above numbers? Yes No (circle one)

Birth date: _____ Birthplace:_____

EMPLOYMENT

Employer: _____ Occupation: _____

Employment address: _____

FAMILY HISTORY

Father: ___Living ___Deceased Current age / age at time of death: ____ Cause of death: _____

Mother: ___Living ___Deceased Current age / age at time of death: ____ Cause of death: _____

List birth order of your siblings, including yourself, indicating number of years between you (see example):
(Example: Older Brother -- 3 yrs. --- Older Sister --- 1 yr. --- ME --- 2 yrs. --- Younger Brother)

Family Birth Order: _____

IN CASE OF EMERGENCY,
PLEASE CONTACT: _____ ***PHONE:*** _____
Name and relationship

REFERRED TO THIS OFFICE BY: _____

Keith Rand, LMFT, CGP, FAGPA - CA Lic. MFC 32393
Individual, Group and Couples Psychotherapy

PSYCHOTHERAPY AND MEDICATION HISTORY

Have you ever sought psychotherapy or counseling before? Yes No (circle one)

If so, when and for how long? _____

Please list all medications you are currently taking along with their purpose: _____

_____

Apart from those medications listed above, have you ever used any of the following?

Anti-depressants	Yes	No (circle one)	Anti-anxiety meds	Yes	No
Appetite suppressants	Yes	No	Laxatives	Yes	No
Sedatives	Yes	No	Muscle relaxants	Yes	No
Pain medication	Yes	No			

FEES AND INSURANCE

Payment by check or cash is requested at the beginning of each individual or couples session, and at the first session of each month for group sessions. Checks returned for insufficient fees are assessed a service charge of $30.00 per check.

Initial here: _____

Those patients who wish to utilize health insurance benefits will be provided with a monthly statement reflecting the service provided and payments made. This statement should be submitted directly to the insurance company for reimbursement, attached to a claim form. Since your insurance policy is a contract between you and your insurer, you are advised to understand its provisions. As the insured, you are entitled to an explanation if your insurer rejects your claim for any reason. Rejection of your claim does not, however, relieve you of your obligation to pay for services provided.

Do you require a monthly statement to seek insurance reimbursement? Yes No (circle one)

CANCELLATION POLICY (Individual and Couples Psychotherapy patients only)

*To avoid being charged for a cancelled session, the session must be cancelled **at least** 24 hours in advance by e-mail to KeithRand@me.com or by leaving a message at (323) 655-4060. Sessions cancelled with less than 24 hours notice will be charged at the full fee. By law, insurance providers may not reimburse patients for fees paid for cancelled sessions.*

Initial here: _____

POLICY AND LAWS REGARDING CONFIDENTIALITY

All information between patient and therapist is held in strict confidence. The only exception to this is that state law requires all mental health providers to report suspected child or elder abuse, and allows for breach of confidentiality if patients disclose a likelihood to be of danger to themselves or others.

Initial here: _____

I have read the foregoing and my signature below attests to my understanding of these policies.

_____ _____

Signature ***Date***