Linda M. Caldwell
Professional Counselor (LPC)
West Ridge Commons
3939 West Ridge Road-West 26th Street
Erie, PA 16506

Today's Date:_____

PATIENT REGISTRATION

LAST NAME_____FIRST_____MI_____
ADDRESS_____CITY_____STATE_____ZIP_____
HOME PHONE_____WORK PHONE_____CELL PHONE_____
BIRTHDATE_____AGE_____SEX: M_____ F_____SS#_____
IN CASE OF EMERGENCY NOTIFY_____PHONE_____CELL_____

RESPONSIBLE PARTY (if other than the patient)

LAST NAME_____FIRST_____MI_____
ADDRESS_____CITY_____STATE_____ZIP_____
HOME PHONE_____WORK PHONE_____CELL PHONE_____
BIRTHDATE_____RELATIONSHIP TO PATIENT_____
EMPLOYER_____SS#_____DRIVER'S LICENSE_____

INSURANCE INFORMATION

PRIMARY

INSURANCE COM #1 NAME_____
ID#_____GROUP/CARD#_____
POLICY HOLDER LAST NAME_____FIRST_____MI_____
CITY_____STATE_____ZIP_____
BIRTHDATE_____AGE_____SEX: M_____ F_____SS#_____
RELATIONSHIP TO PATIENT_____EMPLOYER_____
EMPLOYER ADDRESS/PHONE_____

INSURANCE INFORMATION

SECONDARY

INSURANCE COM #1 NAME_____
ID#_____GROUP/CARD#_____
POLICY HOLDER LAST NAME_____FIRST_____MI_____
CITY_____STATE_____ZIP_____
BIRTHDATE_____AGE_____SEX: M_____ F_____SS#_____
RELATIONSHIP TO PATIENT_____EMPLOYER_____
EMPLOYER ADDRESS/PHONE_____

RELEASE OF INFORMATION PERTAINING TO THE PATIENT

There may be times we would like to informally contact others such as family members, caseworkers, or ECCM about your progress. We refer to this type of informal communication as "Personal Communications." Please fill out this form to help guide us in providing Personal Communications about you.

1. Please indicate whom else we can communicate with concerning your growth and/or treatment. (Please initial)

_____My spouse, please name_____DOB_____Phone_____
_____My children, please name_____DOB_____Phone_____
_____My parent(s), please name_____DOB_____Phone_____
_____My caseworker, please name_____DOB_____Phone_____
_____ECCM worker, please name_____DOB_____Phone_____
_____Other, please name_____DOB_____Phone_____

APPOINTMENTS AND CANCELLATION POLICY:

In the first session, the assessment will be performed. Typically, the length of a session is for 53 + minutes. Once an appointment is scheduled, you are expected to attend each session; this is **your** time period. If you decide to cancel and if the therapist does not have a 24-hr cancellation (1 business day), advance notice, you will be expected to pay $40.00 for the session missed. I understand emergencies, but I need to hear from you by phone. My voicemail does record the date and time of your message. It is important to note that the insurance companies do not provide reimbursement for cancelled session, nor is the cancellation fee reimbursable.through insurance coverage. After three (3) sessions of no-show, no call, or less than a 24-hr notice, you will be asked to find another therapist and services will not be continued. A missed appointment w/out a 24-hr notice reduces the time that could be available for other clients who need the services.

_____ _____

Signature of Patient Date

PROFESSIONAL FEES AND FINANCIAL RESPONSIBILITY

I understand and agree at the time of service that:

a) If you have an insurance deductible, you are required to pay for each counseling session until you have met your deductible. My hourly fee is $125.00 for the first initial session and each individual session of : hourly fee / $100.00
b) All co-pays are expected due at the time of service.
c) In case of NSF checks, the client will be responsible for a $25.00 fee including the amount of the check. If not paid, this may involve hiring a collection agency or going through small claims court which may require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment in his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, it's cost will be included in the claim.)
d) In additional to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing any other services you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs. You will be charged $100.00 per hour for each hour that is spent out of the office in relation to your case.
e) You are required to present your insurance cards if you have a change of insurance or a secondary insurance.
f) There is a $150.00 fee for any written report that is required.
g) It is advised that you contact your insurance carrier to determine your benefits. Insurances pay only a percentage of the total fees. Some insurances will reimburse only after the participant has meet their deductible therefore it is the participant's responsibility to pay the therapist the hourly fee until the deductible is met.

_____ _____

Signature of Patient Date

PROFESSIONAL SERVICES

Please circle any of the following that apply to you:

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal Thoughts	Separation	Divorce
Finances	Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness	Sleep
Stress	Work	Relaxation	Headaches
Tiredness	Legal Matters	Memory	Ambition
Inferiority Feelings	Concentration	Education	Career Choices
Health Problems	Temper	Nightmares	Marriage
Children	Appetite	Stomach Trouble	Cutting
Being a Parent	My Thoughts	Physical Problems	Bulimia

Privacy Notice
Received_____(yes)
Signature_____
Date_____
Read but not taken_____

_____ _____

Client Name: (Printed) Date:

_____ _____

Client Signature: Witness

My signature above stipulates that I understand the appointments and cancellation policy and professional fees and cancellation policy. I hereby authorize Linda M. Caldwell, MA/LPC/EMDR to provide counseling services and to bill for such services to your insurance carrier.