Terry Clowney, MSW
Licensed Clinical Social Worker

Patient Information:

Name (First, Middle, Last): ______________________________________ Age: ________

Street Address: ____

City: _________________________ State: ______________ Zip code: ________________

Home Phone #: _____________________ Cell Phone #: __________________

Okay to leave message: ☐ Yes ☐ No

Date of Birth: ____________________ Email Address (Optional): _______________________

Place of Employment: _______________________How long: ______________________

Spouse/Parent's information (if applicable):

Spouse/ Parent's Name: ____

Home Phone #: _____________________ Cell Phone #: __________________

Spouse/Parent's Place of Employment: ______________________

Work Phone #: _______________________

Person to notify in case of emergency (Name): ________________________________

Phone Number of emergency contact: ____________________________

Referred by: ____

Please read the following and sign below to indicate your understanding and agreement of this information.

Counseling/ psychotherapy is an interactive process in which a client can experience support and change. Best results are likely to occur when the client has clear goals and a defined issue or symptoms for focus in treatment. You or your physician may have already established these areas of focus and goals before referral. If not, we will do that together as we begin treatment.

Patients are seen in consultation for counseling or psychological services at L3Harris Family Medical Center as part of a comprehensive treatment plan. If your physician has referred, you for these services you will be scheduled for a maximum of 15 sessions of brief therapy. At the fifteenth session, you and your therapist will review progress to date with a goal of completing treatment. If further sessions are required, your therapist will consult with your physician to determine the most appropriate course of continued treatment and determine if an outside counselor is indicated.

The information, which you share in psychotherapy, is confidential. Knowing this allows you to work on difficult and personal issues. In general, unless I have your consent, no information, which would otherwise be confidential, will be released. However, there are certain legal limits to confidentiality which include: indications of abuse to a child, elderly or handicapped individual, if the clients condition may pose a serious threat to his or her life or someone else, or a court order. In these rare cases, information, which would be released, is usually for someone's protection.

Part of the purpose of providing these psychological services is to ensure continuity of care. Therefore, in order to provide the best quality of care, I am requesting your consent to consult with your primary care physician. If you give that consent, please indicate by signing here: ____.

Psychotherapy sessions are usually scheduled for 45-50 minutes. Because much this much time is set aside specifically for you, and because consistency is an important part of treatment, at least 24 hours advance notice of cancellation is required. If you are unable to keep your appointment and this notice is not given, you will be responsible for the co-pay for that missed session.

I understand, voluntarily agree to participate in psychological services. I have read the above information and have been given an opportunity to have any questions I may have answered.

Client's Signature: ________________________________ Date: ___________________

Parent/Legal Guardian Signature: ____________________________ Date: _________________
(If patient is under 18)

Witness: ____