Today's Date:_____

CLIENT INFORMATION

First Name:_____ M.I.:___ Last:_____ Date of Birth: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Preferred phone: _____ Other phone: _____ May we leave a message? Y N

Email address: _____ May we send you emails for scheduling only? Y N

Your Employer: _____ Job title or type: _____

Emergency contact: _____ E.C. phone: _____ Relationship to you : _____

If using insurance, please provide the following:

Insurance Company (e.g., Blue Cross, Aetna) & state if state other than LA:_____

Policy # (member ID) including letters: _____ Group # (if on card): _____

Deductible each year: _____ Deductible remaining this year:_____ Copay (specialist): _____

Secondary (Supplemental) Insurance Co. (if applicable)_____ Policy # (Member ID): _____

If someone else (e.g., spouse/parent) is the primary insurance holder, list the following for primary holder:

Primary's Name:_____ M.I.:__ Last:_____ Date of Birth: _____

Current Healthcare Providers:

_____

_____

_____

Current Medications:

_____

_____

_____

Current or Past Medical Issues: _____

_____

_____

Please summarize:

Employment History: _____

Educational History: _____

Where you grew up, have lived: _____

Spiritual orientation if relevant for counseling: _____

Psychological Concerns (please check all that apply, and if possible, rank in order of importance):

Relationships with:
- __ Family
- __ Friends or coworkers
- __ Spouse/romantic

__ Anxiety
__ Depression
__ ADHD
__ Bipolar (Manic-Depressive)
__ Substance Abuse
__ Eating or body image

__ Health/physical/pain
__ Victim of Abuse
(Physical, Emotional, Sexual)

Harm to others:
- __ Thoughts of hurting others
- __ Assaults

Harm to self:
- __ Thoughts or plan to harm self
- __ Previous suicide attempts
- __ Other harm (self-inflicted wounds)

__ Financial troubles
__ Death, loss, grief
__ Career
__ Spiritual
__ Finding meaning
__ Increasing satisfaction
__ Increasing performance
(Work, hobbies, sports)
__ Healthy lifestyle
(food, fitness, relaxation)

Please describe any previous counseling, psychotherapy, or treatment with psychotropic medications including approximate dates, where you went, reasons for seeking treatment, and whether you benefitted.

_____

_____

Please check all that apply or have applied to any members of your family, even if not formally diagnosed:

___Anxiety
___Depression
___Alcohol Abuse
___Drug Abuse
___ADHD
___Bipolar Disorder
___Schizophrenia
___Eating Disorders
___Domestic Violence
___Emotional/Physical/Sexual Abuse
___Psychiatric Hospitalization
___Suicide
___Homicide
___Other problems

Healthy Lifestyle Questions

Caffeinated drinks (6 oz coffee)/day ___ Servings of sugar (all sources)/day _____

Alcoholic drinks/week _____ Cigarettes/day _____ Exercise sessions/week _____

Relaxation sessions (stretching, prayer, meditation, walking dog, reading to child, etc.)/week ___

Hobbies? What do you do for fun?_____

Passions? What do you love or have you loved in the past?_____

Please list names and ages of key people (family, children, romantic, friends):

_____ _____ _____

_____ _____ _____

Any Goals for Counseling:_____

Any Preferred Tasks or Method for Counseling:_____

DISCLOSURE AND INFORMED CONSENT

Purpose

This document informs you of your rights and responsibilities as a client, and to fulfill the requirements of the State of Louisiana for the provision of psychological services.

Confidentiality

All information discussed or written during your treatment is confidential, protected both by law and the American Psychological Association Code of Ethics, and may not be released to others without your written consent. However, exceptions to confidentiality include: an order of court, mandatory requirements to report suspected child abuse or neglect, and situations where you exhibit evidence of immediate danger to yourself or others. These exceptions are the requirements of the law, designed to protect you and others. Please inquire if you have any questions about confidentiality or the exceptions.

Nature of Counseling/Psychotherapy

Psychotherapy is the process where psychological issues and disorders are assessed, evaluated, and treated. There are a variety of techniques that can be utilized to deal with the problem(s) that brought you to therapy. The research literature indicates that a majority of people improve from psychotherapy. Potential benefits include reduction in feelings of anxiety or depression, better interpersonal skills, better coping skills, and improvement of specific problems. Psychotherapy has some risks that include the experience of uncomfortable feelings or recalling unpleasant events in your life. A psychotherapist is not in control of your life. You are responsible for all your decisions and actions. Unfortunate events may happen to you while in psychotherapy. Your therapist cannot control the many factors and events in your life, and is not responsible for unfortunate events that may happen in your life.

Privacy & Recording

Dr. Weibel will not record any part of any sessions in any manner without prior permission. Likewise, by signing this form, I agree not to record any part of any sessions without prior permission.

Appointments

Please call (225) 678-9389 to schedule your appointments. If you are unable to keep an appointment, please notify Dr. Weibel 24 hours in advance to or you will be charged the full fee, not the co-pay.

Emergencies & 24 hour coverage

If you or a loved one ever experience a mental health emergency: Call 911, Go to a local hospital emergency room, call the COPE Team (225) 765-6565, the 24 Hour Crisis Line at (225) 924-3900, or the National Suicide Prevention Lifeline (800) 273-8255. I understand that Dr. Weibel is not available by phone at all hours. He is not part of a clinic or hospital, with other doctors answering his emergencies. If I need a higher level of care, I will make it known now.

Fees

The fee is $200 for the initial session and $125 per 50-minute session for individual therapy. Your payment is a tax deductible medical expense. Payment is due at the time of service.

Insurance

If Dr. Weibel is a provider for your insurance company and you decide to use your insurance, by signing this form you authorize payment of medical benefits to Dr. Weibel for services provided, and you authorize the release of any medical or other information necessary to process this claim. If Dr. Weibel is not a provider for your insurance, he will provide you with a receipt should you desire to seek insurance reimbursement.

Consent

I have read and understand the preceding information regarding my rights and responsibilities as a client. I consent to receiving counseling and/or other psychotherapeutic services provided by David Weibel, Ph.D. and agree to abide by the requirements outlined above.

_____	_____	_____
Printed name of client	Signature of client	Date
_____	_____	_____
Parent or guardian name (if client < 18)	Signature of parent/guardian	Date
_____		_____
David T. Weibel, Ph.D., Licensed Clinical Psychologist (#1137, renewal date 7/31/18)		Date

Dr. David T. Weibel & Associates, LLC
7931 Picardy Ave, Suite B
Baton Rouge, LA 70809
Tel: 225-678-9389 Fax: 225-208-1065
d@drweibel.com

Acknowledgement of Receipt of Notice of Privacy Practices

I (Client Name)_____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

It is your right to refuse to sign this document

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Others: _____