

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:                                 | <input type="checkbox"/> Health/physical/pain               | <input type="checkbox"/> Financial troubles      |
| <input type="checkbox"/> Family                     | <input type="checkbox"/> Victim of Abuse                    | <input type="checkbox"/> Death, loss, grief      |
| <input type="checkbox"/> Friends or coworkers       | (Physical, Emotional, Sexual)                               | <input type="checkbox"/> Career                  |
| <input type="checkbox"/> Spouse/romantic            | Harm to others:   | <input type="checkbox"/> Spiritual               |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Thoughts of hurting others         | <input type="checkbox"/> Finding meaning         |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Assaults                           | <input type="checkbox"/> Increasing satisfaction |
| <input type="checkbox"/> ADHD                       | Harm to self:   | <input type="checkbox"/> Increasing performance  |
| <input type="checkbox"/> Bipolar (Manic-Depressive) | <input type="checkbox"/> Thoughts or plan to harm self      | (Work, hobbies, sports)                          |
| <input type="checkbox"/> Substance Abuse            | <input type="checkbox"/> Previous suicide attempts          | <input type="checkbox"/> Healthy lifestyle       |
| <input type="checkbox"/> Eating or body image       | <input type="checkbox"/> Other harm (self-inflicted wounds) | (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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Bipolar Disorder  | <input type="checkbox"/> Emotional/Physical/Sexual Abuse |
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Schizophrenia     | <input type="checkbox"/> Psychiatric Hospitalization     |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Eating Disorders  | <input type="checkbox"/> Suicide                         |
| <input type="checkbox"/> Drug Abuse    | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Homicide                        |
| <input type="checkbox"/> ADHD          |  | <input type="checkbox"/> 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, the client, agree not to record any part of any sessions without prior permission.

### Appointments, Scheduling, & Email

Please call 678-9389 to schedule your appointments. If you are unable to keep an appointment, please notify Dr. Weibel 24 hours in advance, or you will be charged the full fee, not the insurance negotiated fee. You can schedule by email, but realize that email is less secure than phone. You assume all privacy risks when emailing. Email is for scheduling, not conducting therapy. Do not include detailed personal information in email.

### Emergencies, suicidality, & 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, and is not part of a clinic or hospital, with other doctors answering his emergencies. If I, the client, 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 7/31/19)

\_\_\_\_\_  
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: \_\_\_\_\_