Dr. Jeffrey Hamsley, Sr.

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Initial Interview Form

Date: _____/_____/_____

Client Information

Name: _____Email:_____
Address: _____City: _____State: ___ ZIP: _____
Phone: (H)_____(W)_____Email: _____
Sex: Male_____ Female _____ Date of Birth: _____/_____/_____
Social Security Number: _____
Others living at home: _____
Employer: _____
Position: _____How long have you worked there? _____
Education: (list high school, trade school, college, and graduate school, etc.):
_____
_____
_____
Primary physician: _____ Phone: _____
List any significant health problems:
_____
_____
List any medications you are presently taking and the dosage:
_____
Have you been in therapy before? Yes_____ No_____
If yes, when: _____
Name of therapist: _____
Give a brief description of issues worked on:
_____
_____
_____
_____
Referred by (therapist, physician, friend, yellow pages, etc.): _____
Nearest relative, other than spouse: _____
Phone: _____ Relationship to you:_____

Confidentiality Statement

All information shared in session is confidential except in circumstances governed by the laws including the mandatory reporting of alleged harm to others, particularly in the case of a child, disabled person, or elder abuse.

Financially Responsible Person's Information

Name: _____ Relationship to client: _____
Address: _____City: _____State: ___ ZIP: _____
Phone: _____(H) _____(W)
Social Security Number: _____
Employer: _____
Approximate Yearly Family Income: _____
Number of Dependents: _____
Insurance Carrier: _____
Group or Member Number: _____
Insurance Phone Number: _____

Financial Agreement

Your fee per session is $_____.
Your insurance company will be billed at $_____ per session.
Your insurance company states they agree to pay $_____ per session.
You have a deductible of $_____ which is _____has _____has not been met.
Your payment or co-payment will be $_____ per session.

The office will make every effort to collect payment from your insurance company. However, you are ultimately responsible for the amount due. YOUR PAYMENT OR CO-PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION.

Cancellation Policy

Counseling sessions are 50 minutes, unless otherwise agreed upon. Your time has been reserved especially for you. 24 HOURS prior notice is required for cancellation of your counseling session, or you will be charged a $30 LATE CANCELLATION FEE. If you stand me up with no telephone call to cancel your counseling session, there will be a NO CALL, NO SHOW fee of $60.

It is understood that charges will be added to your account for Professional Services rendered by your therapist (i.e. - phone contacts over 5 minutes, preparation of special forms, reports, court time, travel time, etc.) The fee for these services is $175 per hour and is not covered by insurance.

Statement of Understanding

My counselor has reviewed this client-counselor agreement with me.

Client: _____ Date: _____

Dr. Jeffrey Hamsley, Sr. _____Date: _____