Helene Schneider, M.A., M.F.T.
License MFT 28083
Psychotherapy and Life Coaching

Client Information

Last Name_____First Name_____Date of Birth_____

Address:_____email:_____

City:_____State:_____Zip:_____

Phone: Cell:_____ Other:_____

I was referred by:_____

Name/Phone # of person to contact in emergency:_____

Medical Conditions/Allergies:_____

Current Medications:_____

Primary Care Physician/Phone #:_____

Do you want me to and give permission for me to contact your physician? Yes_____ No_____

Payment Policy: Clients are expected to pay for each session the day of the appointment. Sessions are 50 minutes. Additional services, letters, reports and extensive in office or phone consultation will be billed at a prorated session fee.

Cancellations must be made at least <u>48 hours</u> prior to the appointment or you will be charged your regular fee for that appointment. If you do not show up for a scheduled appointment, you will be charged the full fee for that session. This applies to sickness or other unfortunate situations that may interfere with your attending the session. Appointment fees may increase annually.

I understand and accept the payment and cancellation policy.

_____

Signature Date

Confidentiality: Psychotherapy and Coaching services are strictly confidential and private. Mental health professionals are legally required to break confidentiality in cases where the client is in danger of hurting themselves, hurting another person, unable to care for themselves, where there is suspicion of child or elder abuse, in some legal matters involving mental health issues, and by the order of the courts.

I consent to the use of telehealth (video or phone) as an acceptable mode of receiving confidential psychotherapy. I understand and accept the confidentiality policy:

_____

Signature Date