

SUSIE ROBINSON, LCSW

Licensed Clinical Social Worker

## REGISTRATION FORM

NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

PHONE: (Best number) \_\_\_\_\_ email \_\_\_\_\_

MARITAL/PARTNER STATUS: \_\_\_\_\_

SPOUSE/PARTNER'S NAME: \_\_\_\_\_

Emergency Contact Name & Number: \_\_\_\_\_

CHILDREN'S NAMES/AGES: \_\_\_\_\_

CURRENT EMPLOYMENT: \_\_\_\_\_

How were you referred?: \_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?  Yes  No

Are you currently taking psychotropic medications (antidepressant, anti-anxiety, etc.)?

Yes  No If yes, please list: \_\_\_\_\_

What is the nature of the problem that brings you to therapy? \_\_\_\_\_

\_\_\_\_\_

**INSURANCE INFORMATION:** Please provide a copy of your insurance card OR

Insurance company name: \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

SIGNATURE CONSENT TO BILL INSURANCE \_\_\_\_\_

Your signature allows me to bill your insurance, but you remain responsible for charges if your insurance refuses payment. Your payment in the form of credit card, cash or check, is due at the time of service. I also accept Pay Pal through my website at [www.somocountytherapy.com](http://www.somocountytherapy.com)

431 Nursery Rd, Suite B-700

The Woodlands, TX 77380

[srfamconnect@gmail.com](mailto:srfamconnect@gmail.com) (281) 658-7988

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## Health and Social Information

How is your current physical health?

Poor            Unsatisfactory            Satisfactory            Good            Very good

Please list any specific health concerns: \_\_\_\_\_

\_\_\_\_\_

Are you having any problems sleeping or eating?    \_\_\_\_\_ Yes            \_\_\_\_\_ No

Please describe: \_\_\_\_\_

If you are married, or in a romantic relationship - on a scale of 1 to 10 - how would you rate the quality of your current relationship? \_\_\_\_\_

In the last year or so, have you experienced any significant life changes or stressors, such as deaths, major illness, moves? Please list.

\_\_\_\_\_

\_\_\_\_\_

Do you consider yourself to be religious or spiritual? If so, what is your faith or spiritual perspective?

\_\_\_\_\_

What do you like most about yourself?

\_\_\_\_\_

What goals do you have for therapy?

\_\_\_\_\_

Additional information you would like for me to know:

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## CONSENT FORM

Psychotherapy is a safe and effective way to address a variety of personal, emotional, and relationship problems. It is completely voluntary on your part, and you are expected to be an integral part in planning and carrying out your treatment plan. There is no minimum number of sessions required, and you may stop therapy at any time without penalty.

**You have the right to confidentiality.** I may not discuss your particular case without your written permission, except in certain circumstances. These include, but are not limited, to the following:

I am required by law to report child abuse, or the abuse of an elderly or disabled person.

I may consult your treating physician without prior notice in the event of an emergency.

If you are suicidal I will contact a family member or your treating physician.

If you are threatening to harm someone else and I believe it is a credible threat, I am required to contact law enforcement.

If I, or my records are subpoenaed I am required by law to comply.

If you are using your medical insurance to pay for sessions, I am required to give your name, ID number, (*which may be your social security number*) a diagnosis, the date(s) of service, and what type of service was provided. I cannot be responsible for the confidentiality of information once I have sent it to the insurance company.

**You have the right to review your client records.** In the event that you wish to review your records, please make a written request to me at the address below. I must comply within 30 days or give reason for my denial. I am allowed to charge reasonable fees for the records request.

**Limitations of services:** I cannot prescribe medication, I do not have hospital admitting privileges, nor do I have any specialized treatment program. Many people need a higher level of care than I can provide, and I will be happy to work with you to find the appropriate level of care, while still providing you with therapy.

**Please give 24 hour notice if you need to change or cancel your appointment.** I am very understanding about emergencies, however, if you miss an appointment without adequate notice, I may charge you for the missed appointment. Two missed appointments will result in termination of services.

My fee for service is \$95.00 per session. Your part of that fee is: \_\_\_\_\_

Client Signature \_\_\_\_\_

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