**Heather Kitchen, MSW, LCSW**
Pathways Counseling Center
2300 W. Meadowview Rd., Suite 208
Greensboro, NC 27407
336/686-1689 ● (FAX) 336/217-8171
www.Greensboro-Counseling.com

# Client Information Sheet

**Date**___________________ **SS#**___________________________________________

**Patient's (Child's) Name**:

_______________________________________________________________________
Last First Middle Maiden

**Address**:_______________________________________________________________
Street or Box Number City State Zip

**Home Phone**:( )____________________ **Business Phone**: ( )____________________________

**Birthdate**:_____________ **Age**:________ **Sex**: M or F **Marital Status**: Sing M Sep D W

**Email address**: _______________________ **Place of Employment**: ____________________________

---

**Spouse/Parent**:_________________________________________________________

**Home Phone**:( )____________________ **Business Phone**: ( )____________________________

**Emergency Contact**:_____________________________________**Phone**:( )__________________

---

**Please circle any problems you are currently experiencing:**

| | | | |
|---|---|---|---|
| Depression/Sadness | Anxiety | Overweight | Eating Problems |
| Stress | Low Self-Esteem | Excessive Worrying | Anger |
| Relationship Problems | Job Difficulties | Chronic Pain | Alcohol Abuse |
| Sleeping Problems | Drug Abuse | Mood Swings | Work Issues |

**How did you learn about our counseling services?**__________________________________________

**Please briefly describe your presenting concerns:**

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

**Please list prior psychiatric or mental health treatment: (when, where, and with whom**): _________

_______________________________________________________________________
_______________________________________________________________________

**Please list all present medications (name, strength, and dosage)**:______________________________

_______________________________________________________________________
_______________________________________________________________________

**Name of Family Physician:**_______________________________**Phone #** ( ) __________________

**(Continue to next page➔)**

©2008, Heather Kitchen, LCSW

# POLICIES AND FEES

I am a licensed clinical social worker practicing psychotherapy, life coaching and seminar presentations. As a private practitioner, I am not enrolled in any managed care companies. This means that pay in full for services at the time of each session. In the case of cancelled appointments (see cancellation policy), pre-paid fees will be applied to the next scheduled appointment. I will accept payment by cash, credit card or check.

**HEALTH INSURANCE & MANAGED CARE**: Your health insurance policy is a contract between you and your health care company. Individuals desiring reimbursement for my services by their health care companies are required to pay in full for each session then submit charges themselves to their companies. I will be happy to assist by providing paperwork and reports that may be required for reimbursement. *All* professional time will be billed at the same hourly rate. This includes report preparation for insurance, legal communications, letters on your behalf, and phone calls (of more than 10-minute duration).

**CONFIDENTIALITY**: In matters pertaining to your psychotherapy, confidentiality will be maintained with the following exceptions. (1) When I think a client is of imminent danger to himself or others; (2) When I decide that consultation with a colleague, psychiatrist, physician, and other staff members as may be necessary in my judgment for your psychological treatment; (3) When I or my staff need to release any psychological or medical information required in the processing of applications for financial/insurance coverage for services rendered. Your signature below signifies that you understand the limitations of confidentiality as described above and also grants your permission for me to consult a colleague or your healthcare providers to discuss your care; and to release information to your insurance company when appropriate.

**OUT-OF-SESSION COVERAGE**: If you need to reach me outside of our regular sessions, please call and leave a message. In most cases, I will return your call within one business day. If you have an emergency, leave a message on my voice mail and I will return your call as soon as possible. If I am away from my office for any reason (vacation, conference, illness, etc.) and you wish to be seen by another therapist in my absence, I will assist you in making arrangements. If you have an emergency and you are unable to reach me, please call or go to the nearest hospital emergency room.

*I understand and agree to the terms specified above:*

**Name**______________________________________________________**Date**______________

**Signature of Client** (If 18 yrs. of age or older) ______________________________________________

**(FOR CLIENTS WHO ARE MINORS)**

I hereby consent on the behalf of ____________________________(client's name), who is a minor, for above state psychological treatment. ( I / We) verify that ( I / We) have (sole / joint) legal custody of said minor ______________________ in order to give permission for treatment.

Name__________________________Signature: ____________________________Date: ______________
(Parent or guardian)

Name__________________________Signature: ____________________________Date: ______________
(Parent or guardian)

**CANCELLATIONS**

I agree that if I (or my child) can't keep my appointment, I need to give 24 hours notice so that this time can be made available to others. If I miss an appointment without notifying Heather Kitchen or cancel with less than 24 hours notice***, I agree to pay the full fee***. Exceptions may be made in the case of unavoidable emergencies.

Name__________________________Signature: ____________________________Date: ______________

**FINANCIAL RESPONSIBILITY**

I agree to pay on demand all charges for services rendered by Heather Kitchen, LCSW, on behalf of the patient. I also understand that if payment is not received that further action may be taken in order to secure such payment.

Name__________________________Signature: ____________________________Date: ______________

©2008, Heather Kitchen, LCSW