VALLEY PSYCHOLOGICAL CENTER

Laurie R. Kroger M.A. M.A.
Licensed Marriage & Family Therapist #80864

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916-789-7082

CLIENT INFORMATION ***Today's Date***____________

Name___________________________Address_______________________

City____________________________State________________Zip_______

Age_____Birthdate_______________Previous Counseling? Yes / No

Phone Numbers: Please check the preferred number to contact you.

Work( )__________________Home( )____________Cell( )_____________

Emergency contact Name_________________________Phone_________

Relationship to you ____

Household Members: (Include Name, Age, and Relationship)

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Names and ages of children if not listed above:_______________________

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Marital Status: Please check all that apply ( )Single ( )Married

( )Separated ( )Divorced ( )Widowed ( )Shared Living Arrangement

If married, how long?____

How many marriages for you and for your spouse?____________________

If divorced, how long ago?____

If shared living, how long?____

Educational Information: Years Completed and any Degrees Earned

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Current Occupation:____

Religious Affiliation:____________________ Do you attend Church? Y / N

Name of church____

Current Medical Doctor:____

Medications you are presently taking:________________________________

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What are your goals for your counseling?_____________________________

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What are sources of stress in your life?_______________________________

I UNDERSTAND THAT I AM RESPONSIBLE TO GIVE 48 HOURS NOTICE OF CANCELLATION OF MY APPOINTMENTS SO THAT I WILL NOT BE CHARGED FOR PROFESSIONAL TIME I RESERVED.

Signature_____________________________________ Date______________

Insurance
While I do not provide insurance billing, if you would like to submit a bill to your plan, I will give you a receipt with all the necessary information and your plan can reimburse you directly. You may want to check with your insurance to see if you have "out-of-network" or "non-participating provider" benefits. Your insurance company can tell you what portion of my fees they will reimburse to you and whether you have a deductible that needs to be met before they begin reimbursement.**PLEASE NOTE THAT INSURANCE COMPANIES REQUIRE THAT I PROVIDE THEM WITH A DIAGNOSIS. You are thereby giving me permission to release limited personal information to them. You would need to discuss with your insurance company how they manage your private mental health information.

Fees and Payment for Sessions
My fee per session is $125.00 for 50 minutes. You may pay by credit card, health savings account, check or cash. Please advise me of any special payment needs. Payment will be due at each session.

Conduct of Therapy
I respect your privacy and will only break confidentiality under conditions required by law, or with your permission. The law requires that I am a mandated reporter for certain possible offenses: elder abuse, child abuse, danger to self, danger to others, mental health legal defense, court orders.

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I have read the above statements and agree to these terms.

Client:__________________________Date:____________________