Kristi Newhouse, LCSW
Licensed Clinical Social Worker

2804 Del Prado Blvd S Suite 109
Cape Coral, FL 33904
239-699-3460

TODAY'S DATE: _____

FULL NAME: _____DATE OF BIRTH:_____

ADDRESS: _____

CITY_____STATE _____ ZIP_____

TELEPHONE:
HOME_____CELL:_____WORK:_____

EMAIL:_____

AGE: _____
MARITAL STATUS:_____
SSN#: _____

EMPLOYER OR SCHOOL (IF STUDENT):
_____

REFERRED BY: _____PHONE: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

_____

NAME RELATIONSHIP PHONE

***If new patient is a minor please provide the following information:**

LEGAL GUARDIAN FULL NAME:
_____

RELATIONSHIP TO PATIENT:
_____

PHONE NUMBER AND EMAIL OF LEGAL GUARDIAN:
_____

FEE POLICY AND AGREEMENT:

Kristi Newhouse, LCSW is committed to providing the most effective and efficient social work treatment and services possible. To do so, it is important that you understand the fee policy and the reasoning behind it.

PAYMENT AND SCHEDULE

Payment is due *at the time services are rendered*, unless other arrangements have been approved in advance by Kristi Newhouse, LCSW. By having you pay at each session, this eliminates the need to bill you. This helps keep this office's costs as low as possible, prevents the accumulation of large debts on your part, and avoids possible risks to your privacy that occur when invoices for service are mailed to you.

You are encouraged to contact this office immediately for assistance if temporary financial problems affect the timely payment of your account.

CHARGES FOR CANCELED/ MISSED APPOINTMENTS

This office requires 24 hours' advance notification if you are not able to keep a scheduled appointment. This notice permits us to offer that time to someone else. If you have given 24 hours' notice, you will not be charged for the appointment. However, if you break your appointment and do not notify this office within 24 hours, you will be charged the price of the missed session. This will automatically be charged to the credit card on file.

We understand that there may be occasional emergencies when you will not be able to keep your appointment and also will not be able to notify us within 24 hours. We will take these circumstances into account.

INSURANCE PROCEDURES

Services provided in this private practice office will be considered out of network. If you wish to submit a detailed receipt with services received from this provider, please ask and Kristi Newhouse, LCSW will provide you with such.

PLEASE INITIAL:

PAYMENT IS DUE AT THE TIME OF SERVICE _____

CASH, PERSONAL CHECK OR CREDIT CARD IS ACCEPTED AT THE TIME OF SERVICE _____

*IF YOU CHOOSE TO PAY VIA CREDIT CARD A **3.5%** FEE WILL BE ADDED TO EACH PAYMENT

ALL THERAPY SESSIONS ARE APPROXIMATELY 45 MINUTES IN LENGTH _____

FEES ARE $125.00 FOR THE INITIAL INDIVIDUAL THERAPY SESSION AND $100.00 THEREAFTER _____

FEES ARE $150.00 (COUPLES/FAMILY) FOR THE INITIAL SESSION AND $125.00 (COUPLES/FAMILY) THEREAFTER _____

YOU WILL BE CHARGED THE PRICE OF THE SCHEDULED SESSION FOR MISSING AN APPOINTMENT OR NOT GIVING AT LEAST 24 HOURS PRIOR NOTICE TO CANCELING AN APPOINTMENT _____

IN ORDER TO PROCEED WITH SERVICES, A CREDIT CARD WILL NEED TO BE PLACED IN FILE AND SECURED. YOU WILL NEVER BE CHARGED WITHOUT NOTICE FROM THIS PROVIDER, FOR INSTANCES OF MISSED APPOINTMENTS.

CREDIT CARD NUMBER_____
EXPIRATION DATE_____
CREDIT CARD CVV NUMBER_____

I HAVE RECEIVED THE TREATMENT AGREEMENT AND DISCLOSURE STATEMENT. I UNDERSTAND AND AGREE TO ABIDE BY MY FINANCIAL RESPONSIBILITIES.

PATIENT SIGNATURE: _____**DATE**: _____

TO ENABLE KRISTI NEWHOUSE WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:

PLEASE BE AWARE THAT FAX TRANSMISSIONS ARRIVE AT THIS OFFICE. CONFIDENTIALITY IS MAINTAINED WITH THESE RECORDS, AS WITH ALL RECORDS IN THIS OFFICE.

MESSAGES RE: APPOINTMENTS MAY BE LEFT ON MY VOICEMAIL OR SENT VIA TEXT: _____YES _____NO

EMAIL MAY BE USED TO COMMUNICATE WITH ME: _____YES _____NO

THE FOLLOWING INDIVIDUALS MAY SCHEDULE AND OR CONFIRM APPOINTMENTS**:**
_____
_____
_____
_____
_____

<u>HEALTH INFORMATION:</u>

LIST ALL CURRENT MEDICATIONS:
_____
_____

NAME OF YOUR PRIMARY PHYSICIAN: _____
MAY WE CONTACT?_____

PHONE NUMBER: _____
WHEN WERE YOU LAST SEEN? _____

I **GIVE MY CONSENT** FOR MY THERAPIST **KRISTI NEWHOUSE, LCSW** TO RELEASE MY RECORD TO MY PRIMARY PHYSICIAN SO THAT THEY CAN DISCUSS MY TREATMENT:
SIGNED_____DATE: _____

I DO NOT GIVE MY CONSENT FOR MY THERAPIST **KRISTI NEWHOUSE, LCSW** TO RELEASE MY RECORDS TO MY PRIMARY PHYSICIAN:
SIGNED_____DATE: _____