Demographic Information

Client

name: _____

gender : please include identity, expression and preferred pronoun:

date of birth:_____

social security number: _____

physical and mailing addresses:

_____

phone numbers:

If client is minor, parent or guardian's name and relationship to client:

_____

gender: _____date of birth:_____

physical and mailing addresses:

_____

phone numbers:

Prior Treatment

Current or prior psychotherapy providers:

Current or prior psychiatric providers:

Current or previous psychiatric medications:

Prior psychiatric hospitalizations, drug and alcohol, residential treatment:

Referral source:

Licensed Marriage and Family Therapist
26384 Carmel Rancho Lane, Suite J Carmel CA 93923 • 831.920.8744 • katherinenewhouse.com

Financial and Legal Agreement

Fees

60-minute evaluation:	150.00
53-minute psychotherapy session:	150.00

FINANCIAL AGREEMENT

I understand and agree that Health Insurance Policies are arrangements between my insurance company and me.

I understand that Katherine M. Newhouse, LMFT will provide information regarding my treatment to a billing service and or insurance company to assist in collection of payment.

I understand and agree that I am responsible for payment for all services rendered at the time the service is rendered.

I understand that if I fail to give 24 hours notice for an appointment cancellation that I will be responsible for payment in full for the missed appointment.

X_____
Name of Client

X_____
Parent/Guardian signature

_____
Date
I consent to treatment by Katherine M Newhouse
Licensed Marriage and Family Therapist

Consent for Treatment of a Minor Child

I agree to therapeutic services provided to my minor child at the office of Katherine M Newhouse, LMFT.

I understand that I have the right to information concerning my minor child in therapy, except where otherwise stated by law. I also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. I therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me.

X_____
Name of Minor

X_____
Parent/Guardian signature

_____
Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a notice/copy of Privacy Practices

X_____

Name of Client

X_____

Parent/Guardian signature

_____

Date