Mary Guzik LCSW **5050 Sunrise Blvd. Suite C-5**
(916) 622-1554 **Fair Oaks, CA 95628**

WELCOME TO THIS OFFICE

Date _____
Name of Client _____ DOB _____
Address _____ City _____ State _____ Zip_____
E-mail _____ Home Phone _____
Cell Phone _____ Work Phone _____

Parent/Guardian Name's _____ DOB_____
Address _____ City _____ State _____ Zip _____
e-mail _____ Phone _____

Occupation of Client or Parent/Guardians' _____
Employer _____ Address _____
Insurance _____ Policy # _____
Group # _____ Phone _____

May we leave messages at these phone numbers? _____ Religion _____Minister/Pastor/Priest _____

Who may we thank for referring you? _____

Names and ages of each person living in the home:

Name_____DOB_____Relationship to the Client___
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Name_____DOB_____Relationship to the Client_____
Name_____DOB_____Relationship to the Client_____

Please read carefully. Your signature acknowledging the following is required for all clients, parents & guardians

Confidentiality
Information obtained during professional contacts with clinicians will be kept confidential (with the below listed exceptions) unless the client or guardian signs a release form waiving this right.

Exceptions
Confidentiality is also waived under the following conditions:

- Your signature on this form indicates your agreement to authorize this office to forward information pertinent to collections to a collection agency in the event of your failure to make payment for more than 60 days.
- The client or guardian becomes plaintiff in a law suite in which your records are relevant. The attorney for the defendant may legally obtain these records, require a deposition, court appearances, etc.
- The client constitutes a threat to self or others. Current interpretation of California law requires that potential victims and/or appropriate authorities be notified of the danger.
- California law mandates health care professionals etc. to report suspicion of child physical abuse, sexual abuse and/or neglect as well as elder abuse.
- If your visit is being paid for by a third party (insurance, EAP, Victim & Witness Assistance, Medi-Cal or county contract for example) your signature on this form indicates your agreement to authorize this office to release all information required by that third party for reimbursement. (This may include clinical, demographic and billing information).
- In order to best serve you, your therapist may consult with other Mental Health professionals regarding your treatment.
- If the client reports sexual exploitation by a therapist, we may be obligated to notify the Board of Behavior Sciences.

_____ _____ _____ _____
Signature of Client or Parent/Guardian **Date** **Signature of Witness** **Date**

Fees
Fees are based on the amount of professional and clerical time involved in services to you. Indirect services such as reports

and phone consultations may be charged. The usual and customary fees for these services are the same per hour as your session's fees. Administrative fees for services beyond standard will be billed directly to you at the same rate.

Payment
Payment and co-payments are required at the time of service. Administrative tasks may require payment in advance of the service. Your payment for therapy will be _____ per 50-minute session.

Workers Compensation
Any client whose injury is work related or work aggravated may sign a lien in favor of this office on any future case settlement. The client will be required in these cases to retain an attorney. If no attorney is retained, the client will be expected to make full payment at the time of service. Cases handled through an attorney will be billed by this office.

Late Cancellations/Missed Appointments
In the event that you fail to provide this office with 24 hour advanced notice for cancellations, **YOU WILL BE CHARGED THE FULL FEE** or the maximum amount payable based on the contract with your third party payer. This amount will not be billed to your third party payer, but will be billed to you directly.

Co-Payments
Your co-payment is_____ and must be paid before each session begins. Your attendance in the absence of co-payment may constitute a late cancellation. Your clinician may refuse to see you and you maybe responsible for the full late cancellation fee, or the maximum amount payable based on the contract with your third party payer.

The client or parent/guardian has confirmed that he/she has read and understands the above information.

_____	_____	_____	_____
Signature of Client or Parent/Guardian	**Date**	**Signature of Clinician**	**Date**