Private Therapy Practice of Anne L. Koenig, M.S., L.P.C.

Confidential Information Form

GENERAL INFORMATION Today's Date_______________

Name____

Date of Birth________________ Age__________

Mailing Address____

____

Home Phone__________________ Work Phone ______________________________

eMail _______________________ Education Level ___________________________

Occupation_________________________ Referred by___________________________

FAMILY INFORMATION

Partner: name, age ____

Children, name(s), age(s) ____

____

(Please note if they are living with you or not)

	Name	Age	Living Y/N	Yrs. Of Education	Occupation	Where located
Father						
	Name	Age	Living Y/N	Yrs. Of Education	Occupation	Where located
Mother						
	Name(s)	Age	Living Y/N	Yrs. Of Education	Occupation	Where located
Siblings						

MEDICAL INFORMATION

Previous therapy experience: name of therapist(s) and date of treatment
____

Name of physician__________________________ Phone number _______________

Please describe any physical symptoms or difficulties you are currently experiencing

____

____

Have you seen a physician about these symptoms?_______________________________

Are you taking prescribed medications? _________ If so, what medications and dosages?

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ADMINISTRATIVE INFORMATION

Payment of Fees: My professional fee is $135 for a fifty-minute session. Please pay for your session at the beginning of each visit with cash or a check. (Returned checks are $25)

Cancellation Policy: Please be advised that I have a **24-hour reciprocal cancellation** policy. You will be charged for my time if you do not give 24 hours notice to cancel an appointment. I will provide your next session at no charge if for any reason I cancel your appointment with less than 24 hours notice to you.

Consent and Confidentiality: You are consenting to treatment under the guiding principles determined by the code of ethics established by the American Psychological Association. In addition, I seek weekly supervision for my case load with a licensed clinical psychologist and bi-monthly peer-supervision. The confidentially of your psychotherapy will be kept unless it is my professional opinion that you present a danger to either yourself or others. No medical information will be disclosed without your notification and consent. Please discuss with me any concerns you may have about this.

I have read and understood the above administrative policies:

Date_________________________Signature___________________________________