

Lee Blackwell, Ph.D.

16152 Beach Boulevard, Suite 170, Huntington Beach, CA 92647 (714)848-7280

California State Psychology License Number Psy 05642

Date _____

Patient name _____ Gender: M F Birth date _____

Fax (____) _____ Cell (____) _____ E-Mail _____

Home address _____ Home phone (____) _____

City/state _____ Zip _____

Driver's License No. _____ Social Security No. _____ Occupation _____

Employer _____ Business phone (____) _____

Business address _____

City/state _____ Zip _____

Please do NOT contact me at: Home ____ Business ____ Cell ____ Fax ____ Email ____ Mail ____

Spouse/Partner

Name _____ Gender: M F Marital status: _____

Driver's License No. _____ Social Security No. _____ Birth date _____

E-Mail _____ Cell (____) _____ Fax (____) _____

Occupation _____ Employer _____

Business address _____ Business phone (____) _____

City/state _____ Zip _____ Bus. Fax (____) _____

Please do NOT contact my partner/spouse at: Home ____ Business ____ Cell ____ Fax ____ Email ____ Mail ____

Other persons living in the home (include name, birth date and relationship):

Family members or important others living outside the home (include name, birth date and relationship): _____

Name, address and telephone number of person referring you:

Physician's name, address and telephone number: _____

Date of last physical examination and findings: _____

Major physical problems and/or medications taken: _____

If previous psychological testing, name, address and telephone number of tester:

If previous psychotherapy or counseling, name, address and telephone number of provider:

Outcome: _____

Reason(s) for seeking consultation now: _____

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Informed Consent for Psychotherapy Assessment Consultation

The purpose of this Initial Assessment Consultation is to determine your needs and to offer you treatment recommendations. This session is for assessment only. Treatment is offered under a separate agreement.

Confidentiality: I am legally and ethically required to keep our sessions confidential. As a result, I will only release information to another professional or other interested party with your written consent, except (1) when subpoenaed in certain legal proceedings in which you give up your right to confidentiality, (2) in cases of behavior that is actually or potentially a serious danger to yourself or others, and (3) specifically, suspected child abuse or abuse of elders or dependent adults. In some cases I would be required to report to public agencies, and possibly to warn those who may be at risk. I will tell you, if possible and prudent, before I make such a report. If you are unclear about anything in this paragraph, please ask me about it as soon as possible.

Appointments: Time is reserved by agreement with you. If you need to cancel or change an appointment time, please give 48 hours notice. Cancellation without 48 hours notice will be charged to you at the regular fee.

Length of sessions: Regular sessions are 45-50 minutes in length. One and 1/2 sessions are one hour and 5-15 minutes, and double sessions are 90-100 minutes in length. These times include the time needed for business matters, such as making appointments and paying for the session. Group psychotherapy is usually 90 minutes.

Fees: Sessions are typically 45-50 minutes. Payment is due at each appointment. Group psychotherapy sessions are typically 90 minutes, and payment is due one month, in advance. Please make checks payable to "Lee Blackwell, Ph.D." In order to use MasterCard or Visa to pay your bill, you will need to fill out a separate form. The fee will increase from time to time to keep pace with rising costs.

Insurance: Insurance will often cover part of the cost of psychotherapy. If you filled out the insurance page, I will provide you with a completed insurance form at the end of each month, for you to sign and send to your insurer for processing. I do not belong to any insurance panels.

Collections: As stated above, payment for services rendered is due and payable in full at the time the service is provided. If any balance remains 30 days following the service date, I (we) agree to pay an additional charge of one and one-half per cent (1½%) per month on the unpaid balance, except where a written agreement exists to extend the payment period. In the event the services of an attorney are required to pursue and/or collect any past due sums, I (we) agree to pay reasonable attorney's fees and collection costs.

Patient signature

Date

Spouse/partner signature

Date

Form date 9/2007

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