MARTHA CARR, Psy.D.
Licensed Marriage, Family Therapist
MFC #30697 • NPI #1407870660
(818) 559-7261

CONFIDENTIAL CLIENT INFORMATION

Date_____

Name_____

Age_____ Date of Birth_____

Address_____

City_____ ___Zip Code_____

Home Phone _____ Work Phone_____

Cell phone_____e-mail:_____

Employer Name and Address_____

_____

Job Title _____

Marital Status_____ Name of Spouse/Partner_____

Children?____ How Many? _____ Ages ____ ____ ____ ____

Who referred you?_____

May I notify that person that you have contacted me? Yes No
Please provide their phone number. _____

Regular Physician (Name & Phone)
_____

Are you taking any medications? (Please list name, dosage and for what condition)

_____ _____

_____ _____

Prescribed by Whom? (Med doctor, Psychiatrist – please also specify name of doctor if different than above) _____

Phone of Doctor (if different than above)_____

Date of Last Visit with Prescribing Doctor_____

Emergency Contact: Name_____

Phone_____

(Skip if not using insurance) Insurance Co._____

Your ID Number_____

Name and ID Number of Member (if different)_____

_____ Member's DOB_____

SAG/AFTRA members please provide Value Options ID _____

Insurance Billing Address:_____

_____Phone:_____

Group Policy No_____

INFORMED CONSENT

CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY:

The therapy relationship is a professional and confidential relationship. What is revealed in this setting is protected by professional and ethical standards, such that, with few exceptions, all material is confidential and not released without your written consent. Ethically and legally, however, there are some exceptions or limitations to confidence. They are:

If there is a reasonable possibility that you will harm yourself or others.
If I have reason to suspect Child, Dependent Adult or Elder Abuse. If I am ordered by a court to release information.

Insurance companies require at minimum that I provide a diagnosis in order for payment. If your plan requires pre-authorization in order for your treatment to be covered, information including diagnosis and treatment will be sent to your insurance company. Copies of forms sent to your insurance company are provided upon request.

CANCELLATION POLICY

At least 24 hours notice of cancellation must be given in order not to be charged for that session. Without such notice it is my practice to charge you full fee for the missed or late-canceled appointment. Exceptions to this include true medical emergencies or unavoidable circumstances. If you need to cancel your appointment before your scheduled time but it is within the 24-hour frame, I will make every effort to re-schedule your appointment at your request. If I can re-schedule it within the same week, the fee for the canceled appointment will be waived. There is no guarantee of availability. Once your hour has started, however, you are responsible for the full fee (not just the co-pay.) I do not bill insurance companies for any part of missed or canceled appointments as that is not a covered procedure.

AGREEMENT:

Your signature is recognition that you have read and understood the above and constitutes a binding agreement between us.

Signature _____Date _____