Laura E. Forsyth, Ph.D. 805.795.2131
1601 Carmen Drive, Suite 211, Camarillo, CA 93010

PATIENT INFORMATION & CONSENT FOR SERVICES

Date_____

Name_____ Phone_____

Cell _____ Best contact # _____ Email _____

Address_____ City, Zip _____

D.O.B._____ SSN _____ Ethnicity (opt.) _____

Martial/Relationship status _____ Name of Spouse/Partner _____

Children (names/ages) _____

_____

Who lives in your household? _____

Occupation _____ Employer _____

Hours worked weekly/schedule _____

Highest level of education _____ Currently a student? _____

Emergency contact: _____ Relationship to you _____

Contact's phone #s (home/work/cell) _____

How or by whom were you referred? _____

Previous counseling or psychotherapy? _____ If yes, please describe what was helpful _____

_____

_____

How is your health? _____ Any health or physical concerns?_____

_____

_____

Any sleep problems? _____

Medical doctor's name, address & phone # _____

_____

Psychiatrist's name, address & phone # _____

_____

If you are taking psychiatric medication now and/or in the past, please describe: _____

_____

_____

Ever hospitalized for mental health or for alcohol/drug treatment? _____

_____

_____

Other information important for me to know _____

_____

_____

Practice policies regarding sessions & Patient responsibility for payment

Regular sessions are forty-five (45) minutes in length, extended sessions are sixty (60) minutes.
Payment is required for late cancellations with less than 24 hours' notice and for missed appointments.
Payment is due at the beginning of each appointment unless other arrangements have been made in advance.

Session Fees: 45 min - $140; 60 min - $160

I understand that when an appointment is made, that time is reserved for me. A 24-hour notice is expected for any cancellation. I accept personal responsibility for the total of the agreed upon fee, even if insurance reimburses some portion of the amount. I am aware that insurance will not pay for a canceled or missed session.

I understand that unpaid bills for therapy sessions, late cancellations and missed appointments that are delinquent beyond 60 days may be turned over to a collection agency. I also understand that I will be responsible for all additional charges or fees associated with collecting the amount due.

For parents or others taking financial responsibility for the Patient: I accept responsibility for the timely payment of Dr. Forsyth's services for my _____ (Relationship), _____ (Patient's name), as summarized above.

I understand that other specific information about the Patient or therapy will not be disclosed without his or her explicit consent.

Printed Name	Signature	Date

Consent for treatment

My signature below indicates that I have read and understand the "Psychotherapy Services, Policies & Agreement" and "Privacy Practices"; I also accept responsibility for payment as summarized above. I give Dr. Forsyth permission to speak with my designated contact person in an emergency. I have had an opportunity to discuss my questions with Dr. Forsyth.

I consent for treatment with Dr. Forsyth under these terms. I understand I may revoke this consent at any time by notifying Dr. Forsyth <u>in writing</u>.

Printed Name	Signature	Date