Zach Lehman, LCSW
Therapy for hope, healing, and growth

CLIENT INFORMATION AND CONSENT FORM

Client Name: ______________________________ Date of Birth: ____________

If the client is a minor, Parent's Name: ______________________________

Home Address: ______________________________

____

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Email Address (optional): ____________ Emergency Contact Name: ____________

Emergency Contact Phone Number: ____________ Social Security: ____________

Referred By: ______________________________ Today's Date: ____________

I welcome you as a client and wish to provide you with the best professional care possible. The information below will answer questions you may have regarding my cancellation, billing, and service policies and procedures.

Cancellation/Missed Appointments Policy

Your appointment time is scheduled and reserved for you only. If you are unable to keep your appointment or need to reschedule, please contact me at least 24 hours in advance. Cancellations must be made by phone only. If notice is given within less than 24 hours, reasonable accommodations may be made for illness, injury, severe weather, or other unanticipated problems at the discretion of this therapist. However, failed appointments where no notice is given will result in a $30.00 failed visit fee.

________ please initial that you have read and agree to abide by this policy

Billing Policy

Payment in full is expected at the beginning of each session. Invoices will be provided to you which you may submit to your insurance provider for reimbursement.

Urgent Need / Emergency Care Services

As a clinician in private practice, I respond to voicemail messages within 24 hours if they are received Monday through Friday. I will respond no later than the next business day if your voicemail message is received after 5pm on Friday. You will be notified by me in advance of any changes to this policy.

In the event of a crisis or an emergency, I will make every effort to respond to your call as soon as possible. However, I may be unavailable at any given time and cannot ensure an immediate response to any call or message you leave me. If you find yourself in need of emergency psychiatric care, dial 911 or seek assistance at the nearest hospital emergency room or crisis center.

I have read both this form and the Notice of Privacy Practices form, and I have had the opportunity to discuss these policies with my therapist _______ (please initial)

Client Name:____________________ Client Signature:____________________ Date:____________