New Client Information - Adult

Date: ______________________________

Name: ______________________________ Birth date: __________

Address: ______________________________

City/State/Zip Code: ______________________________

Daytime Phone: ______________________________ Mobile Phone: ______________________________

Evening Phone: ______________________________

Email: ______________________________

Information:

I am currently employed ___full-time ___part time at:

Employer/Company Name ______________________________

City, State : ______________________________

Hours I work: ______________________________

Please describe any current concerns you have regarding your employment: ______________________________

____

____

I am currently attending school: ___full-time ___part time at: ______________________________

General class schedule: ______________________________

____

Major: ______________________________

Highest level of education completed: ___ High School ___ Junior College ___ College/University ___ Trade

Degree(s): ______________________________

Please describe any current concerns you have regarding your schooling: ______________________________

____

3756 Grand Avenue • Suite 401 • Oakland, CA 94610
Phone (510) 444-8732 • Fax (510) 444-8734 • www.thinksocialeastbay.net

Is there someone at school that we may contact?

Name, Title____

Telephone , Email address____

I am living independently (in my own home/apt.)

I have a roommate/housemate and share expenses. ______________________

I am married.   Number of years?______________________________

I am divorced. ____

I have children.

I am responsible for my own expenses. ___________________________

I get financial assistance for my expenses.

I am living in my parent's home. ______________________________

I have other living arrangements.

I have been diagnosed (please include the name of the person who gave you the diagnosis and the date you received it):

____

Current Medications:____

____

On a separate sheet, please write a one page description of why you are seeking assistance from our clinic.

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Clinic Policies– Very Important, Please Read and Initial

I agree to follow the fee schedule and policies for ____as noted:
(print your name)

Therapy sessions: $110 per 60-minute session when 2-4 students in the group.
$120.00 for individual session.

Additional consultation: $155.00 per hour for consultation with parents, report writing, IEP attendance (travel time is billed as well), phone calls exceeding 10 minutes with a therapist.

Please Initial Each Section

___ **Absences and Missed Session**
Each clinic participant is allowed 2 cancellations over the course of the school year without being billed for those cancellations, if your child started therapy with us in the Fall. If your child started therapy with us after January 31st, the child is allowed 1 cancellation. Cancellations may be due to illness, schedule conflicts, vacations, etc. Beyond these 2 cancellations, you will be billed for missed sessions. If cancellations persist, you will be asked to give up your spot in the clinic. I understand that notification of temporary absence from therapy for illness, vacation, etc., must be given 24 hours in advance if possible and not later than 7:30 am on the morning of the scheduled appointment.

The clinic closes during the 2 days of Thanksgiving, the 2 weeks of the winter holiday (December-Jan), and we are closed for the following holidays: Labor Day, President's Day and Memorial Day. We are open for Veteran's day and Martin Luther King Day. We run the weekly sessions until school closes again in June. If you find you cannot continue at the clinic for any reason, we require a two week notification of withdrawal to allow our staff to fill that slot. Your deposit will be applied to the last two sessions. If you are unable to provide a two week notification of withdrawal, your deposit will be applied to cover a two week notification.

___ **Policy for most of the group being absent one week**
When the therapists work in the group, they observe small details that they wish they had time to cover more intimately. When all the other clients in the group are absent, we will see you individually, at the same price as if it was a group session. This is an excellent time for receiving individual feedback and encouragement.

___ Policy for processing insurance claims or other administrative tasks:
We are a "private pay" clinic, meaning that all of our services must be paid for by the guardians of the client, or the adult client themselves. We do not accept 3rd party reimbursements.

___ Policy for billing:
Billing statements/invoices are issued at the end of each month for weekly therapy sessions. Payment is due by the 15th of the month.

Please sign below and bring these pages to the clinic on the first day of your session. Copies of these policies will be available for you to take for your reference.

Signature ____ Date____________________

Print Name ____

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