Marital & Family Psychotherapy Services

Laura R. Brooks LCSW-C
5074 Dorsey Hall Drive, Suite 104
Ellicott City, MD 21042
443.956.7282
www.maritalandfamilytherapyservices.com
info@laurarbrooks.com

Date_____

Name_____**Birthdate**_____

Address_____

_____

Telephone: **Home**_____
Cell_____ **Please check preferred number.**
Work_____

Email Address _____

Place of Employment _____**Job Title** _____

Emergency Contact_____ **Tel**. #_____

Names of others you live with:

_____**Age**_____

_____**Age**_____

_____**Age**_____

_____**Age**_____

Referred by:_____

INSURANCE INFORMATION (if applicable)

Name of insurance company _____**Telephone #**_____

Subscriber's Name _____**ID #**_____

Authorization #_____**Co-pay**_____ **# of sessions**_____

Claims Mailing Address_____

_____

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Policies and Procedures

CONFIDENTIALITY: The content of your sessions is private, except when there is a threat of harm to self or others, or if there is a history of abuse involving minors. Your written permission is required for me to share any information about your treatment with anyone else, such as your doctor, family member or lawyer. In instances when I have to complete a form for insurance authorization, I will develop it with you so you will know its content. All files are kept secure.

NOTICE OF CANCELLATION: The time for your appointment is being held for you and there are others who would like to have that time if you cannot be present. Therefore, if you are unable to make a scheduled appointment, cancellations of at least 48 hours prior to the appointment will be appreciated so that someone on the waiting list can fill your time slot. All cancellations made within less than 24 hours prior to the scheduled appointment which cannot be filled from the waiting list will result in the full charge being made to you. Insurance companies will not reimburse for a missed appointment. Please note that weekends and holidays are not considered as part of the notice time, so that a Monday cancellation must be made by Friday of the previous week.

EMERGENCIES: This practice does not provide 24-hour, seven day a week emergency care. I will return your calls in a timely manner but in the event I cannot be reached during an acute emergency, please use the services of your local hospital or the hotlines in your community.

FEES: Fees are due at the beginning of each consultation so that we can end the session on time and I can be punctual with the next patient. If you plan to use insurance, I can provide a written statement of fees paid for you to submit to your insurance company. My fee is $140.00 per 45-50 minute session.

INSURANCE REIMBURSEMENT: I suggest that you verify your insurance benefits and pre-certify the initial session if need be. I assume you will keep track of the number of authorized sessions. When they expire, I will complete any required forms required by your insurance company for continued authorization.

I have read and understand the above policies. I understand that payment is to be made at the beginning of each consultation and that I am financially responsible for all scheduled appointments unless a minimum of 24 hours notice, as described above, is given.

Client(s) or Parent/Guardian _____Date _____