J.ARONSON THERAPY

PATIENT INTAKE

Patient's Name: _____ Date: ___/___/_____

Home Address: _____

_____

Date of Birth: ___/___/_____ Home #: (___)_____Cell #: (___)_____

Email: _____

Name of person responsible for bill payment: _____

Current Doctor: _____ Phone #: (___)_____

Current Nutritionist: _____ Phone #:(___)_____

Current Psychiatrist: _____ Phone #: (___)_____

Referred by: ☐ Internet ☐ Yellow Pages ☐ Friend: _____
☐ Doctor: _____
☐ Other, specifically: _____

REASON FOR REFERRAL: _____

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Please note the fee/cancellation policy located on the following page. Thank you.

FEE/CANCELLATION POLICY

This is a reminder about standard appointment practices. Please be sure to keep them in mind when scheduling and/or canceling appointments.

RATES

$250 Consultation (approximately one hour)

On-going sessions run approximately 50-55 minutes.

Please note an additional fee will be charged for paperwork that cannot be filled out during one's session. In addition, fees may be added for team phone calls and other external collaboration. (Customary insurance reviews not included)

PAYMENT OPTIONS

Cash, Check, or Credit Card. Venmo payment accepted.
All Venmo or electronic payments are required on the day of scheduled session.

CANCELLATION POLICY

Cancellations must be made 48 hours in advance. Payment is required for sessions that are not cancelled 48 hours in advance. Please email or call as text messages do not apply.

1. Please provide your credit card information to keep on file. If you do not show up for an appointment, your credit card will be charged for a missed session.
   Credit Card #_____
   Exp._____ Security Code_____ Zip Code_____

2. All psychotherapy sessions require **payment due at time of service**.

Thanks in advance,
Jessica Aronson, LCSW-R, ACSW, CGP, CEDS

Please read the above and sign the form agreeing to these conditions regarding the **fee at time of service.**

X_____ Date_____
Client Signature

X_____ Date_____
Client Signature (Client's Parent/Guardian if under 18)