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

$350 Consultation (approximately one hour)

On-going sessions run approximately 50-55 minutes.

*Additional fees may apply for extensive clinical forms and paperwork filled out by psychotherapist. In addition, there is a charge for scheduled collaborative team phone calls and customary insurance reviews.*

PAYMENT OPTIONS

Check or Credit Card.
*All electronic payments are required on the day of scheduled session.*

CANCELLATION POLICY

Please note that there is a 48-hour business day cancellation policy to avoid being charged for an appointment. Monday appointments must be rescheduled by Friday to avoid a charge. 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)