Gretchen D. Woosley, MSW, LCSW

New Client Data

Date: _____Referred by: _____

Name: _____

DOB: _____

Address: _____

Home Phone: _____ Work/Cell Phone: _____

Email Address: _____
Emergency Contact: _____

If Adult:
Occupation and Employer:_____

Marital/Relationship Status:_____

If Child:
Custodial parent/guardian name: _____

Other parent/guardian name: _____

Marital/Relationship status of parents:_____

Names and ages of siblings: _____

Adults and Children:

Date of last physical: _____

Physician: _____ Phone: _____

Current medications: _____

Health Status: _____

Reason for appointment: _____

What do you hope to accomplish in counseling?

_____

_____

Has client ever been in counseling before?_____
If so, when and with whom? _____

Insurance company: _____
Policy Holder Name and DOB: _____
ID# _____
Group # _____

Office Policies

1. EMERGENCIES: If you have a psychological emergency, you may call the office and I will return your call as soon as possible. If it is after hours and you cannot safely wait for a return call you should call 911 or the Behavioral Health Center Call Center at 704-444-2400.
2. Cancellations: There will be no charge for appointments cancelled with a 24 hr. notice. **If an appointment is not cancelled 24 hours before your appointment time, you will be charged the full fee.** Monday appointments should be cancelled the Friday before.
3. There is a $25 service charge on all returned checks.
4. Payment is expected at the time of service. If you wish me to file insurance for claims I will do so for insurance companies where I am an in-network provider. For other insurance companies, I will provide you with the information you need to file with your insurance company. Please note that you are ultimately responsible for all fees incurred and that your insurance will not cover late cancellation fees or case management services. You are responsible for these charges.

By signing this consent, I acknowledge that I had the opportunity to discuss my treatment with my therapist, have read and accept the above policies, agree to and contract for treatment.

Signature_____ Date_____