Howard Lindemann, lcsw
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Confidential Questionnaire

To be completed prior to initial meeting

Full Name ______________________ Today's Date ____/____/ 2016

Street ______________________ City ____________ State ______ Zip ________

Telephone Home ( ) ____________ Mobile ( ) ____________ Work ( ) ____________

E-mail address ______________________ Leave messages at ☐ Home ☐ Mobile ☐ Work ☐ Email

Birth date ____/____/______ Social Security No. ______________________ ☐ Male ☐ Female

☐ Employed ☐ Retired ☐ Student ☐ Single ☐ Married ☐ Other:

Employer or School ______________________

Name of Emergency Contact ______________________ Telephone ( ) ____________

Who referred you? ______________________ May I contact? ☐ Yes ☐ No

If using insurance please have insurance card available

Insurance Company ______________________ Authorization No. ____________

If the insurance policy holder or person responsible for payment is someone <u>other</u> the individual listed above please complete the following information for the insured or responsible person

Name ______________________ Birth date ____/____/______

Street ______________________ City ____________ State ______ Zip ________

Telephone Home ( ) ____________ Work ( ) ____________

Relationship of Insured or responsible party to person seeking therapy: ☐ Spouse ☐ Parent ☐ Child ☐ Other

Insurance ID No. ______________________ Group No. ____________

Social Security No. ______________________

FEE POLICIES

In order to provide the most effective and efficient services possible your understanding and cooperation regarding the following financial provisions is necessary. Please read the information on the next page and note any questions you may have.

Payment schedule. Payment is due at the time services are rendered, unless other arrangements have been approved in advance. Please ask for assistance immediately if temporary financial problems affect the timely payment of your account.

Insurance Procedures. If you have medical insurance, this office will assist you in receiving your maximum allowable mental health benefits. If you wish, claims can be filed through this office or you may file your own claim. $ 145.00 is the standard fee for a 50-minute session and is considered usual, customary, and reasonable by most insurance companies. Some insurance companies, however, reimburse on a schedule that is below the current standard. Depending on your insurance, you may be required to pay out of pocket the difference between $ 145.00 and the insurance reimbursement**.** Please note that although insurance claims are filed as a courtesy to my clients, all charges from the date service is rendered are your responsibility.

Managed Care Provider Networks. Third-party payer systems may require referrals from your primary care physician, pre-certification by the managed care organization and copayments at each session. Copayments cannot be waived and must be paid at the time of service. However, the copayment is your only out-of-pocket expense, and our reimbursement is directly from the third-party payer. In this instance, our relationship is with the provider network as well as with you.

Payment Methods. Cash, money orders, personal checks, MasterCard, VISA, Discover and American Express credit cards are accepted. Returned checks will be subject to a $25.00 charge, which will be added to your bill. Balances older than 90 days will be subject to interest charges of 1% per month. Unpaid balances older than 180 days and in excess of $300 may be a basis for terminating service. In this unfortunate event, effort to help you locate alternative care will be made; however, I may be unable to continue to work with you in the face of financial default.

Late and Canceled Appointments. 24 hours' advance notification is required if you are unable to keep a scheduled appointment. This notice permits me to offer someone else an appointment. If you have given 24 hours' notice, you will not be charged for the appointment. However, if you break your appointment and do not call this office within 24 hours, you may be charged for the session.

I understand that there may be occasional emergencies when you will not be able to keep your appointment and will not be able to make notification within 24 hours. These circumstances will be taken into account. Charges for broken appointments and appointments canceled without 24-hours' notice cannot be billed to your third-party payer. You will be personally responsible, therefore, for the full amount of the session.

If you are late for your appointment without 24 hours' notice, you may be seen for the balance of your time but charged for a full session. If you provide 24 hours' notice of an expected late arrival, your fee may be prorated.

By signing below, I am indicating that I have read the above statements on fees and payment policies. I have discussed these conditions with Howard Lindemann and have had the opportunity to ask questions. My questions have been answered to my satisfaction. I understand and agree to meet my financial responsibilities in receiving treatment and services in this practice setting.

I agree to

______ remit to Howard Lindemann, lcsw at the beginning of each session a fee of $__________, which is based on a rate of $145.00 per treatment hour.

______ remit to Howard Lindemann, lcsw co-payment in the amount of $__________ in keeping with the policies of my health benefits and assign my applicable health insurance benefit to Howard Lindemann, lcsw.

Client name (please print) ____

Signature ____ Date ____/____/____

Family

Please indicate the names and ages of the following

Spouse/Partner ______________________________

Children ______________________________

Siblings ______________________________

Parents ______________________________

Education and Occupation

Years of education Degree or diploma Currently a student ☐ Yes ☐ No

Current occupation ______________________________ Time at this position ____________

Satisfied with your work (explain) ? ______________________________

Health Care

List current physicians, psychiatrists and other professionals and the reasons for seeing them ______________________________

____

Current medications and dosages ______________________________

____

List below prior counseling, psychotherapy, or psychiatric services you have received. Include hospitalizations, chemical dependency treatment, relationship counseling, individual therapy, etc.

Dates	Where /with whom	Reason	Helpful?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Why are you seeking help at this time? ______________________________

____

____

What are your goals for therapy? ______________________________

____

____

Please indicate below the problems that you are experiencing

- ☐ addictions
- ☐ alcohol
- ☐ anxiety
- ☐ career
- ☐ children
- ☐ chronic pain
- ☐ concentration
- ☐ confusion
- ☐ death
- ☐ depression
- ☐ divorce
- ☐ drugs
- ☐ eating
- ☐ fatigue
- ☐ financial
- ☐ grief
- ☐ guilt
- ☐ health issues
- ☐ impulsivity
- ☐ isolation
- ☐ legal
- ☐ loneliness
- ☐ memory
- ☐ motivation
- ☐ phobias
- ☐ physical abuse
- ☐ post traumatic stress
- ☐ relationships
- ☐ self-esteem
- ☐ sexual
- ☐ sexual abuse
- ☐ sleep
- ☐ stress
- ☐ suicide
- ☐ violence
- ☐ weight
- ☐ other - list below

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