402 West Broadway
Suite 400
San Diego, CA 92101

Email Karen@therapyinsd.com
Phone 619-889-0662
Fax 888-974-1286

Kerschmann and Associates

PATIENT INFORMATION

Date_____ DOB _____ Age _____

Name _____ Phone (Home/Cell) _____OK to leave msg?_____

Email _____

Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____ Phone _____

Occupation and workplace_____

For clients under 18:
Guardians names: _____

Phone numbers: _____

FAMILY INFORMATION

Relationship Status _____

Who do you live with?_____Pets?_____

Children's names and ages _____

Parent's names and ages _____

MEDICAL HISTORY

Personal Physician and Contact _____

Psychiatrist or Other Medical Providers_____

Current Medications and Dosages (Include non-prescription)
_____

Date of Last Medical Exam _____ Results _____

Do you use any substances? _____ Frequency /Type_____

Have you had mental health treatment before? _____ Dates _____

With whom, where and why? _____

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PRESENTING ISSUES

What brings you to therapy now? _____

_____

What would you like to achieve in therapy? _____

_____

How did you find my office (Friend, MD, Google, etc)?

_____

RESPONSIBLE PARTY FOR BILL (if other than patient):

Name _____ Relationship to patient _____

Address _____ City _____ State ____ Zip _____

SS# _____ DOB _____ Phone_____

Employer

Address _____ City _____ State ____ ZIP _____

PLEASE CHECK: Private Insurance ( ) Cash ( ) Other ( )

( ) At times I bring Bella, a 10 lb poodle mix to the office. Please check if you prefer that she is **not** present during your appointment.

CONFIDENTIALITY: Communication between patient and therapist is privileged except child, elder or dependent abuse and/or a threat to the life of another person. If you have managed health care, their utilization review panel will be involved. Confidentiality law binds them.

RELEASE OF INFORMATION: This form must be signed and approved by you if you wish that records or information go out of the office except to your insurance/managed care provider.

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage and for missed appointments or cancellations with less then 24 hours notice. A copy of this signature is valid as the original.

The fee for a 45-minute session is $140.00 and $250.00 for 90-minutes. Payment is due at time service

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The time for your appointment is reserved strictly for you. If you cannot attend your session, please call to cancel 24 hours in advance or you will be charged a missed appointment fee of $100. If you are over 15 minutes late to your session without calling you will be considered a no show. There are no exceptions to this policy.

I consent to assessment and treatment under the care of Karen L. Kerschmann, MSW, LCSW.
I have read and understand the above stipulations.

Signed _____ Date _____

Signed _____ Date _____