**CONFIDENTIAL CLIENT INFORMATION FORM**

**Colleen Russell, LMFT, CGP**
**Licensed Marriage and Family Therapist (MFC29249); Certified Group Psychotherapist (41715)**
**San Francisco Bay Area, Marin County, California**
**Phone: 415-785-3513; Email: crussell@colleenrussellmft.com; Website: www.Colleenrussellmft.com**

Name: _____

_____ Date: _____

Street Address: _____

City, State, Zip: _____

Date of Birth: _____ Telephone: (H) : _____(W): _____ (Cell): _____

Email: _____

Emergency Person and Number to Call: _____

Referred By: _____

Previous/Current Psychotherapy or Counseling From: _____To: _____Therapist(s)' Name(s)

_____

Was your experience in therapy positive? Briefly explain: _____
_____

Medical Information: ( Past and Current Medications and dosages, Conditions):
_____
_____
_____

Single ___Married ___Partnership ___Divorced /When? ___Bereaved/When?___ ___

How Long in Current Relationship? _____Partner's Name: _____

Children? Ages:
_____
_____

Occupation and Position or Current Enrollment in School:
_____

Highest Education: _____Degree: ____ Subject: _____

What major losses have you experienced, and When? _____
_____
_____
_____

What brings you to therapy or counseling, individual, couple, family, or group?

_____
_____
_____
_____

What strengths do you have?

_____
_____
_____
_____

Fee: We have agreed on a fee of $175.00 private pay for the consultation/initial session or continuing sessions. Fee for group is $50 or $70 depending on the group.

Superbill if requested:

If you request a "Super Bill" I can provide one that you can send to your insurance company so you may get reimbursement for our sessions. I cannot guarantee your insurance will reimburse you, nor do I know for what amount. It is your responsibility to ascertain this information. I have opted out as an insurance provider so I can spend more time with clients. Payment is required at the time or prior to services received.

_____ _____

_____ _____

Signed Name(s) Date

_____

_____

Printed Name(s)