Dr. Janice Avalone, Psy.D., LMFT

Licensed Marriage & Family Therapist
Lic# MFC 106305
949-973-6442 E-mail: drjaniceavalone@gmail.com
www.drjaniceavalone.com

PATIENT REGISTRATION

Fee $ ____200__ (per session)

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female
Marital Status:
□ Single □ Domestic Partnership □ Married □ Separated □ Divorced
□ Widowed Spouse/Partner name: _____ Phone:_____

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone_(_____)_____May I leave a message? □Yes □No

Cell/Other Phone: (_____)_____May I leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

How would you like to be reminded about appointments:
☐ Cell Phone (Number and Carrier): _____
☐ Email:_____

Emergency Contact: _____ Phone:_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes
□ No

Please list and provide dates: _____

_____

Who referred you to Dr. Janice Avalone, LMFT? _____
Medical doctor: _____ Date of last physical:_____

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Informed Consent

Please read the following information carefully:

FEES: Payment for session is due at each session. Dr. Janice Avalone LMFT is accepting no insurance plans (PPOs, HMOs, etc.)

Cancellation must be made 48 hours before session or full payment will be required (if you do need to cancel, please leave a message on my phone service [949-973-6442] and not by e-mail because I don't always check my e-mails).

Please Initial _____

CONFIDENTIALITY: Dr. Janice Avalone, LMFT offers individual, couples, family and group counseling services. I understand that records concerning my treatment will be kept confidential and retained as allowed by law. Dr. Janice Avalone, LMFT may share information about me as necessary for treatment, and I understand that my consent must be given to release information about me.

EXCEPT in the following situations: (please initial)
___If a client expresses a serious threat to harm an identifiable person, the counselor must warn that person and the police
___If a counselor is made aware of possible child abuse or neglect or the abuse or neglect of a dependent adult, the appropriate agency must be notified.
___If a client is a danger to him/herself, and the individual is unable to contract adequate safety measures, hospitalization must be requested.
___Confidential records must be released in the event of a court order.
___If using insurance through use of a Superbill provided by Dr. Janice Avalone, I grant Dr. Janice Avalone, LMFT to release information requested by those entities for billing purposes.

If it is agreed that exchanging information would be helpful for the therapeutic process, an "exchange of information" form will be used for the client to grant permission for the exchange of information.

I have read and understand the information on this consent form. Dr. Janice Avalone, LMFT has explained, in a language that I understand and to my satisfaction, what giving consent means. I understand that I can withdraw my consent and terminate services at any time.

I hereby authorize Dr. Janice Avalone, LMFT to provide services to:

_____ _____

Name (please print) Date

_____

Signature

_____

Parent/Legal Guardian (please print)

_____ _____

Signature of Parent/Legal Guardian Date