Dr. Janice Avalone, Psy.D., LMFT

Licensed Marriage & Family Therapist License # MFC 106305
949-370-7671 E-mail: drjaniceavalone@gmail.com

www.drjaniceavalone.com

PATIENT REGISTRATION

Fee $ ____200___(per session)

Client Name: _____

Parent Name if child is under 18 years:

Parent Name: _____

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)

Cell/Other 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: _____

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: _____

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 not accepting 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 text or leave a message at 949-370-7671)

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.

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:

Signature _____ Date_____

Signature_____ Date_____