CURRY
PSYCHOLOGY GROUP

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NEW CLIENT INFORMATION FORM

Please allow approximately 30 – 45 minutes to complete this form. We realize that we request quite a bit of information from clients at the start of therapy. Please bear with us, as this step will help us understand multiple influences in your life so that we can be as effective as possible in understanding your current situation and helping you reach your goals. Your information will remain confidential, so please answer as openly and honestly as possible. The more information we have, the better equipped we are to help.

Today's Date: ____________________

I. DEMOGRAPHIC INFORMATION

Patient Information

Patient name: ______________________________ Date of birth: ____________ Age: __________

Home address: ____ Apt.: __________

City: ____ State: ______ Zip: ___________

Employer: ___________________________________ City of Employment: _________________

Job Title: ____

Cell Phone: ________________________ Home Phone: ______________________________

Work Phone: _______________________ e-mail: __________________________________

Calls or e-mail will be discreet, but please indicate any restrictions: ______________________________

May we send a text message or email appointment reminder the day before your appointment? ☐Yes ☐No

Insurance Information

Insurance company: ____

Insurance ID # (*For Tricare, enter sponsor's social security #*): ___________________________________

Patient's relationship to the sponsor/primary insured: ☐ Self ☐ *Spouse** ☐ *Child/Dependent**

Sponsor name: ___________________________________ Date of birth: ____________________

Sponsor insurance ID# (*For Tricare, enter sponsor's Social Security #*): _____________________________

Sponsor job title & employer (*Military, enter branch, MOS & rank*): _____________________________

Emergency Contact

Name: ______________________ Relationship: ______________ Phone: ____________________

Address: ____

How did you learn about us?

❑ Online Search ❑ Psychology Today ❑ Insurance Directory ❑ Referred by: ______________________

If referred, may we have your permission to thank this person for the referral? ❑ Yes ❑ No

If referred, how did this person explain how we might be of help to you?

____

____

II. Personal Identity

Race/Ethnicity

Ethnicity/national origin: ___________________________ Race: ___________________________

Other related way you identify yourself: ____

Religion/Spirituality

Current religious denomination/affiliation: ____

Religious/Spiritual Involvement: ❑ None ❑ Some/Irregular ❑ Active

How important are spiritual concerns in your life? ______________________________________

Which (if any) church, synagogue, temple, or meeting are you involved with? ________________

Gender Identity

☐ Bigender (*having two genders*)

☐ Female

☐ Gender fluid (*identification is fluid/shifting between two or more genders*)

☐ Male

☐ Non-Binary (*unbounded gender*)

☐ Omnigender (*possessing all genders*)

☐ Other: ____________________

☐ Transgender female (*non-identification with male sex assigned at birth*)

☐ Transgender male (*non-identification with female sex assigned at birth*)

Sexual Orientation

☐ Asexual (*lack of sexual or romantic interest in members of any gender or sex*)

☐ Bi-Sexual (*sexual or romantic interest in both men and women*)

☐ Gay (*sexual or romantic interest in members of the same gender or sex*)

☐ Heterosexual (*sexual or romantic interest in a member of the opposite sex or gender*)

☐ Lesbian (*sexual or romantic interest in women by women*)

☐Other:__________________

☐ Pansexual/Omnisexual (*sexual or romantic interest for people of all genders & sexes*)

☐ Questioning (*still exploring or unsure of sexual orientati*

III. Social History

Relationship Status (please check *all* that currently apply):

❑ Breaking Up
❑ Dating
❑ Divorced
❑ Committed Relationship
❑ Domestic Partnership
❑ Living Apart
❑ Living Together
❑ Married
❑ More than One Relationship
❑ Open Relationship
❑ Other: ________________
❑ Polyamorous Relationship
❑ Separated
❑ Single

Name(s) of current spouse/partner(s): ____

If divorced or separated, name of ex-partner(s):_______________________________________

Are you satisfied with the current quality of your relationship or love life? ❑ Yes ❑ No

If you answered *no*, please describe why: ____

____

Residential History: Please list all the places you have lived in the *last 5 years*.

Year - Year	City, State	Reason for moving	Any issues transitioning?

Household Information: Please list all people living in your household (use back for additional people).

Name	Relationship to Patient	Age	Profession

Family Tree:

Please list any immediate family members *who are not in your household* (parents, siblings, children, spouse). Include non-relatives or extended family members who have played a particularly important role in your life (e.g., a grandparent, aunt/uncle, or family friend who was responsible for your care).

Name	Relationship to Patient	Age *(if living)*	Profession	City, State

Childhood:

Where were you born and raised? ____

Were your parents together when you were born? ❑ Yes ❑ No

If *yes*, are they still together? ❑ Yes ❑ No: *How old were you when they split?* _________

Who was your primary caregiver growing up (*may be more than one*)? ___________________

How was love and/or affection shown in your household? ______________________________

____

Education:

Highest level of education completed/degree(s) received: ____________________________

Have you ever received special education services, academic accommodations (e.g., prolonged test time), a 504 plan or IEP? ❑ No ❑ Yes - *grades & services received:* ______________________

____

Please list *high schools*, *colleges* or *universities* attended:

Grade levels	School	Area of study	Degree or N/A	Reason for leaving (if did not graduate)

Legal

Please list any prior arrests, restraining orders, or legal charges:

Year	List Reason for Arrest/Restraining Order/Current Charges	Legal Outcome

IV. MEDICAL HISTORY

***Major Medical History*:** Please list any major medical conditions, serious illness or accidents, hospitalizations, medically necessary surgeries, or neurological events including loss-of-consciousness, seizures or convulsions.

Age	Illness/Diagnosis	Treatment(s) Received/ Medications Prescribed	Provider/Hospital	Outcome

Current Medical Provider: *From whom do you currently receive medical care?*

Physician Name: ___________________________________

City: ________________________________ **Phone:** _______________________________

Health Habits

1. **What kinds of physical exercise do you get?** ____

2. **How much coffee, cola, tea, caffeine do you consume each day?** ___________________________

3. **Do you try to restrict your eating in any way?** YES NO (Circle one)

If *yes*, describe *how*: ___________________________

If *yes*, describe *why*: ___________________________

4. **Do you have any problems getting enough sleep?** YES NO (Circle one)

Average hours of sleep per night: ________

If *yes,* what problems (falling asleep, staying asleep)? ___________________________

6. **Are you satisfied with the frequency of sex in your life?** YES NO (Circle one)

If *no*, what frequency would you prefer? ___________________________

7. **Are you satisfied with the quality of your sex life?** YES NO (Circle one)

If *no*, how would you like the quality to improve? ___________________________

8. **Do you drink alcohol?** YES NO (Circle one)

If *yes*, how many drinks do you have each day? ___________________________

9. **Do you use recreational drugs?** YES NO (Circle one)

If *yes*, what drugs and how much/how often? ___________________________

____

10. **Are there any medical or physical problems you are concerned about?** ___________________________

____

Women Only

Menstruation

1. If you currently menstruate, do you experience pain with your period? If so, how severe is the pain?

____

2. Do you experience mood changes with your period? If so, please describe:

____

Menopause

1. If your menopause has started, at what age did it start? _______________
2. What signs or symptoms have you had? ___________________________

Please list all pregnancies:

Age	Outcome of Pregnancy (e.g., Abortion, Delivery, Miscarriage, Stillbirth)	If you delivered, please describe any problems with delivery:

V. Mental Health History

Prior Mental Health Treatment

Please list any prior mental health treatment you received and any diagnosis. Include visits to a therapist, counselor, psychiatrist, psychologist, social worker, or mental health clinic, as well as any psychiatric hospitalizations, substance abuse treatment, or other residential treatment facilities.

Age	Issue/Diagnosis	Treatment(s) Received/ Was it helpful?	Provider or Hospital	Reason for termination

Are you currently seeing another mental health care provider (psychologist, psychiatrist, marriage & family therapist, counselor, or social worker)? ❑ **No** ❑ **Yes** *(If yes, please complete below)*

Provider's name & title: ____________________

Phone: ____________________ **City of Office Location** ____________________

How long have you been under this provider's care? ____________________

Reason for care: ____________________

Do you plan to continue care with the above provider? ____________________

Psychotropic Medications & Vitamins/Supplements

Please list any prescribed medications or herbal supplements that you have taken in the last 10 years to treat *mental health symptoms*.

Medication	Approximate dates (or age)	Purpose	Prescribed/supervised by

Family Mental Health History

Please list any members of your immediate or extended family who have been either formally diagnosed or suspected to have a mental illness, *including* substance and alcohol use disorders (e.g., depression, anxiety, alcoholism, addiction).

Name & Relationship to Patient	Illness/Issue	Diagnosed (Yes/No)	Please indicate any treatment history or other notes about what you know of their illness

History of Abuse

Were you ever abused as a child? ❑ Yes ❑ Unsure ❑ No

If you answered *yes* or *unsure*, please indicate any instances below that apply:

- ❑ Emotional abuse (underline any that apply) - *Willfully causing mental suffering of a child or endangering a child's emotional well-being through: Belittling; ridiculing; humiliating; name-calling; excessive screaming, cursing, raging at child; demeaning jokes; excessive teasing about capabilities or physical appearance; refusing love, attention or touch; shunning child from family; unpredictable, unreasonable & extreme reactions; locking child out of the home to discipline or punish; threats or intimidating behaviors; unreasonable demands placed on child; excessive or unreasonable punishment for typical childhood behaviors; isolating a child from peers or prohibiting normal play/opportunities for stimulation; promoting or rewarding unhealthy or criminal behaviors; exposing child to violence in the home; exposing child to other inappropriate or traumatic events)*

- ❑ Neglect – *Failure of caregiver to provide adequate food, clothing, shelter, or supervision (may or may not result in any physical harm to child)*

- ❑ Physical abuse – *Bodily injury inflicted on a child by willful cruelty, unjustifiable punishment, or corporal punishment*

- ❑ Sexual abuse – *Victimization of a child by sexual activities including molestation, indecent exposure, fondling, rape, incest, and exposure of a child to sexually inappropriate content (verbally or visually).*

Crisis & Coping

Briefly list any major crises that have occurred in your life *in the last 5 years*, and how you handled them:

____

____

____

____

During extremely difficult times in life, it is not uncommon for people to have thoughts about suicide. Please describe any times in your life when you experienced *thoughts* about ending your life (e.g., imagined it might be a relief from the pain you were suffering or thought it might be "the only way out" of your difficulties, etc.).

____

____

____

____

If you had such *thoughts*, but never attempted suicide, what prevented you from doing so?

____

____

____

If you have ever had a *plan* to commit suicide, please describe (1) when, (2) what stressors were occurring in your life, (3) whether you had the means available to you to carry out your plan (e.g., access to a lethal dose of medication or a weapon in the house, and (4) what prevented you from carrying out the plan:

____

____

____

____

If you have ever *attempted* suicide, please describe (1) when, (2) what stressors were occurring in your life, (3) the method used, and (4) how the attempt was intervened:

____

____

____

____

Please indicate whether you have experienced *thoughts* of suicide *within the last month:* ❑ No ❑ Yes

If *yes*, do you have a plan for how you would carry it out?

❑ No ❑ Yes (describe): ____

If *yes*, do you have the means to carry it out (e.g., access to a weapon, pills, etc.)?

❑ No ❑ Yes (describe): ____

Has a family member attempted or committed suicide (parent, aunt/uncle, grandparent, sibling, child)?

❑ No ❑ Yes (please describe): ____

Have you ever engaged in any self-harming behavior (e.g., cutting)?

❑ No ❑ Yes (please describe): ____

VI. Strengths & Resources

What are your major strengths? ____

____

____

When are you happy, relaxed, or enjoying yourself? ________________________________

____

____

What people and activities support or comfort you when you are struggling? ______________________________

____

VII. Goals for Therapy

In your own words, please describe what brings you here today: ______________________________

____

____

____

When did this issue begin? ____

***Please check any additional items below that are a concern for you*.**

- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Acculturation issues (adjusting to different culture)
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (believing things that aren't real)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Discrimination
- ❑ Disorganization
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Gambling
- ❑ Gender identity
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Hearing voices
- ❑ Housework/chores—problems, schedules, sharing duties
- ❑ Identity issues
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk-taking
- ❑ Legal matters, charges, suits
- ❑ LGBTQIA issues
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems

- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Paranoia
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Racism
- ❑ Relationship problems (friends, relatives, or work)
- ❑ School problems
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual identity
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other
- ❑ Shyness
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stalking
- ❑ Stress, relaxation, stress management, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats
- ❑ Trauma
- ❑ Violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, overworking, can't keep a job, dissatisfaction, ambition

❑ Other concerns or issues: ____

Please look back over the concerns you have checked off. Which one do you *most* want help with?

____

What changes are you hoping therapy might lead to? ____

____

____

____

____

Thank you for taking the time to answer these questions. We look forward to helping you reach your goals!

CURRY
PSYCHOLOGY GROUP

POLICIES AND PROCEDURES

I. THE INITIAL INTAKE APPOINTMENT / ASSESSMENT PHASE

The first appointment is a face-to-face "intake assessment." All intake paperwork must be completed prior to the initial session. This session is an opportunity for both the client and the therapist to assess mutual compatibility for an ongoing therapy relationship. The therapist will ask questions to obtain a comprehensive history of the presenting problem and assess the best course of treatment based on your goals for therapy. Depending on the complexity of the case, a second intake appointment may be required to complete the assessment. When enough information has been gathered, the therapist will provide you with recommendations for treatment.

On some occasions, the therapist may determine that a client's needs are outside the scope of the services offered in the individual therapy setting, or that the client is unlikely to benefit from the services offered without additional supports. In such cases, the therapist will provide information and guidance regarding next steps and will assist the client in arranging any recommended appointments with outside providers or facilities to ensure that an effective plan of care is in place.

II. PAYMENT

Credit card information will be obtained at your first appointment with the Curry Psychology Group. You or your payer will be charged at the time of each appointment according to the fees outlined in the Financial Policies (see attached form). If you have an accepted insurance plan, the office will charge you the appropriate copayment as derived from your insurance company's eligibility database. If after charging for the copayment, the office comes to know through your insurance's Explanation of Benefits that the amount due is greater or less than the amount originally charged to you, the office will appropriately bill you for the difference and/or refund the excess to your patient account as applicable. The Curry Psychology Group is not liable for any copay, coinsurance, or other obligations reported to our office by your insurance company. Should you have questions regarding your coverages, please contact your insurance carrier for details. If you seek reimbursement from an insurer, our office will submit claims on your behalf at your request.

III. CANCELLATIONS

Since scheduling of an appointment involves the reservation of time specifically for you, we request notice of changes to an appointment **by noon at least one business day prior**. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Insurance companies do not reimburse for missed sessions. (For Monday appointments, cancellations must be made by noon on the previous Friday. For appointments occurring the day after a holiday, cancellations must occur by noon on the prior business day.)

IV. Routine Phone Calls & Email

Contact regarding administrative matters. Administrative and scheduling questions may be left on your provider's confidential voicemail or sent to your provider via email. On weekdays, we will typically return administrative calls and emails within 24 hours.

Contact regarding clinical matters. To ensure that we can fully attend to our clients' needs, we ask that all clinical matters be discussed in-person, over the phone, or via our secure online therapy platform to ensure that there is direct and clear communication. **Please do not contact your therapist by text message**, as this is neither a reliable nor secure mode of communication.

V. Emergency Procedures

In the event of a clinical emergency, such as acute thoughts of harming oneself or others or experiencing a traumatic life event, you may leave a message on your provider's confidential voicemail indicating the nature of the emergency, and your provider will return your call as soon as possible. Please understand that your provider may not be available, especially after-hours or on weekends. **Therefore, if you feel you are in imminent danger to yourself or others or if you feel that your health is at risk, please visit your nearest emergency room; dial 9-1-1; or call the National Crisis Lifeline day or night for free immediate support at 1-800-273-8255.**

Frequency of between-session emergency contact. Please note that requests for emergency contact between scheduled sessions is to be limited to true clinical emergencies only. In cases when a client requires more than two standard duration appointments per week, continued treatment with the provider will be contingent on the client's acceptance of a higher level of care (intensive outpatient, partial hospital, or inpatient treatment), involvement of family members in monitoring safety and compliance (if appropriate), psychiatric support with medication compliance, and/or other modifications of treatment to enhance the client's stability.

VI. The Roles of Therapist versus Evaluator

Litigation Limitation. The ethics and rules of our profession preclude us from serving in a dual-role of therapist and evaluator. As your therapist, we will not be conducting a formal evaluation and therefore do not have a valid and reliable basis from which to provide an expert opinion to any third party. Furthermore, due to the private nature of the therapeutic process, it is agreed that this process should be protected and should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on our clinicians to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Letters & Other Statements of Opinion. Similarly, we do not provide statements of opinion or recommendations in written letter, report, or client forms, unless explicitly retained for the purposes

of a psychological evaluation. If an established therapy client requires evaluative services, we will provide appropriate referrals.

VII. Termination of Treatment by the Provider

The Curry Psychology Group reserves the right to terminate treatment under certain conditions which compromise the therapist's ability to provide effective services, the client's ability to benefit from services, or when it is legally and/or ethically appropriate to do so. Such circumstances include, but are not limited to:

- Three missed appointments or late-cancellations within a six-month period
- Non-adherence to the treatment plan
- Non-compliance with practice policies & procedures
- Refusal to accept a higher level of care or supplemental care when clinically indicated
- Behaviors that are disrespectful, devaluing, threatening, or otherwise inappropriate toward the provider, staff, other clients, or any persons present in the building
- Misrepresentation or omission of pertinent clinical information
- Non-payment of fees

VIII. Privacy

The Curry Psychology Group will not disclose details of your treatment nor your medical record to third parties without your written approval. Our providers operate in accordance with the HIPAA laws. By signing our policies document, you acknowledge that you understand your rights under the HIPAA laws and can freely discuss these rights with your provider. You understand that if you are not the payer for services provided, matters related to billing may be discussed with the payer. You also acknowledge that you have received notice of the privacy policies.

IX. Limits of Confidentiality

Information collected by providers in evaluation and treatment of patients is considered confidential. However, there are certain instances where such healthcare providers are required or allowed by law to make exceptions to this confidentiality. Examples of these situations include the following:

1. The patient authorizes a signed release of information to a designated recipient.
2. The therapist is provided with information leading her to believe that a patient is at risk for harming self or others, or is unable to meet his/her basic needs.
3. Information presented to the therapist that indicates that child or elder abuse/neglect is occurring.
4. A court has ordered release of records.
5. Other reporting requirements mandate release of client information (i.e., a client with dementia whose ability to operate a motor vehicle is potentially compromised).
6. A third-party payer (i.e., an insurance company) is involved in payment. Insurance companies usually require information on dates or service, diagnoses, and types of office visit, but other information may be required before payment is authorized.

X. Consent to Treatment

I acknowledge that I have received and have read (or have had read to me) the introductory forms provided to me about the therapy I am considering. I have had all my questions answered fully.

I understand that developing a treatment plan with my provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided.

I am aware that I may stop my treatment with this provider at any time. The only thing I will still be responsible for is paying for the services I have already received.

By signing below, I acknowledge that I have read the above policies/procedures and am undertaking treatment with the Curry Psychology Group with full awareness and acceptance of the policies and procedures governing this practice:

____ __________________

Signature of Client or Guardian **Date**

____

Printed Name

AGREEMENT TO PAY FOR PSYCHOLOGICAL SERVICES

CANCELATION POLICY (ALL CLIENTS):

Please contact the office at 949-258-9777 to cancel any upcoming appointment. Cancellation of an appointment must be made by noon on the business day prior to the appointment. Since alternative bookings are unlikely after that time, our policy includes a charge of the full session fee for "no show" or late cancellations occurring with insufficient notice. This represents the amount of time reserved for your service. Note that this fee is not eligible for payment or reimbursement by insurance.

If cancelling an appointment that is scheduled on a Monday, notice must be received by our office on the Friday prior to the appointment. Cancellations received during the weekend will be considered late and the fee will apply. Similarly, if an appointment is scheduled the day after a holiday, notice of intent to cancel must be received by the last business day prior to the holiday.

PAYMENT POLICY:

You or your payer will be charged at the time of each appointment according to the fees outlined in the attached fee schedule. We are in-network with Tricare West military insurance. We also bill out-of-network insurance plans with a deposit for the full service fee. Credit card information will be obtained at your first appointment with the Curry Psychology Group and automatic payments can be arranged for future sessions. Acceptable payment methods include credit card and cash.

To check your out-of-network insurance benefits, we recommend that clients contact their insurer at the number listed on the back of their insurance card to ask the following questions:

1. Does my plan include out-of-network benefits for mental health/behavioral healthcare?
2. What is the maximum allowed amount if I receive individual psychotherapy, service code 90837, at an office, with a psychologist?
3. What percentage of the allowed amount does my plan pay?
4. Do I have an insurance deductible that I would have to pay before my out-of-network benefits are provided?

TRICARE WEST/MILITARY BENEFICIARIES:

Clients with Tricare West will be charged the appropriate copayment or deductible fee (as shown to our office from Tricare West's eligibility database) at the time of each appointment.

If, after charging for the copayment or deductible fee, the office comes to know through your insurance's Explanation of Benefits that the client's amount due is greater or less than the amount originally charged to the client, the office will bill the client for the balance *or* refund the excess to your patient account as applicable. The client accepts financial responsibility for all eligible services that are not paid by their insurance plan within 30 days of the date of service.

FEE SCHEDULE BY PROVIDER

SERVICES OFFERED	DR. SHANNON CURRY	DR. NICOLLE BUGESCU	KARI A. FISHER, LCSW, MED	DR. CAREY INCLEDON	DR. FRANCESCA PARKER	DR. GISELA VEGA
Therapy Services						
INITIAL INTAKE APPOINTMENT	300. (55 min)	195. (50 min)	195. (50 min)	195. (50 min)	175. (50 min)	175. (50 min)
INDIVIDUAL THERAPY (ADULT OR CHILD)	250. (55 min)	175. (50 min)	175. (50 min)	175. (50 min)	150. (50 min)	150. (50 min)
FAMILY THERAPY	275. (55 min)	200. (50 min)	200. (50 min)	200. (50 min)	175. (50 min)	175. (50 min)
Supplemental Services						
BETWEEN-SESSION PHONE CONTACT Per 15 min	75.	60.	60.	60.	50.	50.
LETTERS AND FORM COMPLETION Per 30 min	150.	100.	100.	100.	90.	90.
Testing & Educational Support Services						
PSYCHOEDUCATIONAL & DIAGNOSTIC ASSESSMENT (Includes Interview, Collateral Data Collection, Testing, Score Interpretation & Report Writing)	NA	200./hour with retainer	NA	NA	NA	175./hour with retainer
SCHOOL VISITS/IEP MEETINGS Up to first 90 min (includes drive time)	NA	350. (≤90 min)	350. (≤90 min)	NA	NA	300. (≤90 min)

By signing below the Client or Guardian indicates their understanding and agreement to the Curry Psychology Group's payment policies and fees as outlined in this document.

____________________________________ ________________

Signature of Client (or Guardian) **Date**

____

Printed Name

CURRY PSYCHOLOGY GROUP

200 NEWPORT CENTER DR., SUITE 204, NEWPORT BEACH, CA 92660 | T. 949.258.9777 | F. 949.258.9749 | CONTACTUS@CURRYGROUP.ORG

Electronic Payment Authorization

Please enter the card information you wish to keep on file for automatic deduction of your session fee, copayment, or insurance deductible (if applicable). Only fees which have been previously disclosed and agreed to by you per the "Agreement to Pay for Psychological Services" will be charged.

The following credit and debit cards are accepted: Visa, MasterCard, Discover and AMEX.

Client Name: ____________________________________

Cardholder Information (*Please indicate the name and address associated with the credit or debit card you wish to use*):

Cardholder Name: ____________________________________

Address: __________________________________ City____________________ State: ______ Zip: ________

Main Phone Number: ___________________ Email: ____

Credit/Debit Card Information:

Card Type (check one): ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Card Number: ____

Expiration Date: ____________ Security Code (3-digit code on back of card): __________

I, the cardholder, authorize fees for services rendered by this practice to be deducted from the credit or debit card listed above.

____________________________________ ___________________

Cardholder Signature Date