Elizabeth G. Lerner, L.C.S.W.

800 Village Square Crossing Suite 218 • Palm Beach Gardens, FL 33410
Phone 561-758-3795

Date: _____

Client Name: _____Age:_____ DOB: _____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: ( ) _____Cell Phone ( ) _____
Place of Employment_____

Client lives with_____
Married_____ Divorced_____ Single_____ Widowed_____

Child(ren)'s Name(s): _____ Sex _____ Age_____ lives at home Y/N
_____ Sex _____ Age _____ lives at home Y/N
_____ Sex _____ Age _____ lives at home Y/N
_____ Sex _____ Age _____ lives at home Y/N

If Child: Mother's Name:_____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Parents are: Married _____ Divorced _____ Separated _____
If applicable, who has legal custody of child?_____

Names and Ages of Siblings_____ Grade and School
Attending_____

Previous mental health contact for self or family members: _____

Primary Physician: _____ Phone ( ): _____
Address: _____ City: _____ State: _____ Zip: _____

List all Physical Difficulties:
_____
_____
Current Medications: Prescribed By:
_____
_____

Do you drink alcohol?_____If yes, how much and when?_____
Do you smoke cigarettes?_____

Do you take recreational drugs?_____

Referred By: _____

I hereby apply consent to psychotherapy, and or consultation with Elizabeth G. Lerner, LCSW understand it is my responsibility to cooperate with treatment.
I authorize payment of medical benefits to Elizabeth G. Lerner, LCSW for services rendered.

Signature _____ Date _____

Charges for services are due and payable at the time services are rendered, unless prior arrangements have been made with the therapist. If you have health insurance, it should be understood that this is an agreement between you and your insurance company to pay you certain amounts for medical care. Your bill is an agreement between you and your therapist. You are responsible for the payment of your bill, regardless of the status of your insurance claim. I do not take insurance. However, I will give you a receipt that you can submit to your insurance company for possible, partial or complete reimbursement. I am happy to help you in any way I can to help you get reimbursed. Sliding scale fees are available.

Signature _____ Date _____

Because time has been reserved exclusively for me and/or my family member(s), I understand that I am required to provide at least twenty- four (24) hours advance notice if unable to keep the scheduled appointment. In the event that I do not provide the twenty-four (24) hours prior to canceling, I am financially responsible for the reserved appointment.
I hereby assume financial responsibility for all charges that may be incurred for treatment rendered to myself and/or my family member(s). I understand the above financial policy. I have also read and understand the Patient's Rights and Responsibilities. I received a copy of these Rights and Responsibilities to retain for my records.

Signed: _____ Date: _____