JESSICA HERSCH ACSW, LCSW, LMFT

MARRIAGE & FAMILY THERAPIST

115 N. College Ave.; Suite 113

Bloomington, IN 47404

812-332-8814

jherschtherapy@gmail.com

CONSENT TO TREATMENT

I enter into an evaluation and treatment relationship with Jessica Hersch, ACSW, LCSW, LMFT for myself and/or my child, or a minor for whom I am a guardian or have custody.

By signing I affirm that I have the authority to sign for myself or have legal custody or guardianship of the named minor. All information is confidential with the exception of reporting statutes for child abuse or neglect or threat of harm to self or others, or if a signed release of information. By signing I affirm I am responsible for payment at the time of service. There will be a charge for the appointment if not cancelled before 48 hours. Charges are based on insurance rates, except for non-covered services, such as forensic testimony, court ordered services, consults, and requested written documents, which are billed at $145/hour. There is a $30 fee for returned checks.

 NAME OF CLIENT: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Birth Date:

NAME OF GUARDIAN, PARENT, OR CUSTODIAN (if minor client): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ADDRESS: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PHONE #s: HOME **(\_\_\_) \_\_\_-\_\_\_\_** CELL **(\_\_\_) \_\_\_-\_\_\_\_** WORK **(\_\_\_) \_\_\_-\_\_\_\_**

EMAIL **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ]** OK to leave message on phone or email

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF CLIENT, PARENT, OR GUARDIAN

I AM RELEASING INFORMATION TO MY INSURANCE COMPANY:

Name of Company **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Insurance Number **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Policy Holder* Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Birth Date of *Member*:

Insurance Name and Phone for Behavioral Health on Card: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**JESSICA HERSCH ACSW, LCSW, LMFT**

**MARRIAGE & FAMILY THERAPIST**

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Reason for treatment:

 Current Mood:

Please state any major medical diagnoses and history which may impact your treatment:

Current medications:

Previous mental health medications:

Reason for stopping medications:

History of mental health treatment: Previous provider and year you were in treatment:

 Reason for previous treatment:

 Reason for ending previous treatment:

Do you have any concerns that the client is suicidal? **[ ]**  Homicidal? **[ ]**

Victim of abuse or neglect?

History of any civil or criminal charges against you and year:

Specific issues important for therapist to know:

How long have you (or the family member) experienced the problem for which you are seeking an evaluation or treatment?

What are you hoping to change?

**JESSICA HERSCH ACSW, LCSW, LMFT**

**Marriage & Family Therapist**

**115 N College Ave.; Suite 113**

**Bloomington, IN 47404**

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**RELEASE OF INFORMATION**

Name of client: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Birth Date:

Information to be Released: **[ ]**  Full Chart **[ ]**  Consultation **[ ]**  Medical Records

**[ ]**  Mental Health Records **[ ]**  School Records **[ ]**  Court/Probation Records

**[ ]**  Only specific information as listed **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I voluntarily request Jessica Hersch release of information to the following people or agencies:

**[ ]** Agree to have alcohol/drug records released **[ ]** Do not agree to release drug/alcohol records

I voluntarily request PERSON/AGENCY TO WHOM I AM RELEASING INFORMATION AND REQUEST THIS AGENCY OR PERSON RELEASES INFORMATION,and CONSENT FOR THIS THERAPIST TO RELEASE INFORMATION INCLUDING MEDICAL, MENTAL HEALTH, SCHOOL, OR OTHER RECORDS, AND CONSULT WITH/

FROM/TO JESSICA HERSCH:

AGENCY/PERSON TO RELEASE TO J. HERSCH: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ADDRESS: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** PHONE: **(\_\_\_) \_\_\_-\_\_\_\_** FAX: **(\_\_\_) \_\_\_-\_\_\_\_**

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated by signing below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF CLIENT, PARTY, PARENT, OR GUARDIAN

Relationship to client **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Witness **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**