

**CLIENT INFORMATION**

Name of Client: \_\_\_\_\_ Date of 1<sup>st</sup> Visit \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

Town/City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Household Members:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

If client is a student; Name of school \_\_\_\_\_ Grade \_\_\_\_\_

From whom or where did you receive my name? \_\_\_\_\_

Name of Physician \_\_\_\_\_ Town/City \_\_\_\_\_

Medications \_\_\_\_\_

Have you received mental health care in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

**Insurance Information**

Name of policy holder \_\_\_\_\_ Policy holder’s DOB: \_\_\_\_\_

Pre-Authorization # (if required) \_\_\_\_\_

**Agreements**

If client is a minor: I authorize Michael R. Kandle, Psy.D. to treat my minor child(ren):

Name(s) \_\_\_\_\_

\_\_\_\_\_  
Guardian’s Signature

\_\_\_\_\_  
Date

**Insurance Authorizations:** I authorize Michael R. Kandle, Psy.D. to bill my insurance company and to have benefit payments assigned to him. If my insurance company requires clinical information in order to authorize treatment or process my claim, I consent to this information being released as well. My consent can be rescinded in writing to Dr. Kandle at any time if desired.

\_\_\_\_\_  
Sign/Date

**Late Cancellation or No Show Policy:** I acknowledge that Dr. Kandle has a 24-hour notice requirement for cancellations. For appointments cancelled with less than 24-hours, or for missed appointments, I agree to pay a \$70 fee. Exceptions are made for hazardous driving conditions.

\_\_\_\_\_ Please initial to signify agreement

**Informed Consent:** A detailed explanation of my practice policies, procedures and the rules governing the professional practice of psychology is provided in my “informed consent” document. It is available in three locations. Please signify that you have accessed this information either from my website (drkandle.com), my practice manual in the office waiting room, or by paper copy at the time of our initial visit. Questions regarding these matters can be asked at any time before, during and/or after treatment occurs.

\_\_\_\_\_ Please initial to signify you have received access to my informed consent information.

## **TRUST AGREEMENT**

Successful therapy requires a lot of trust. Some of this trust is blind, that is, clients must start by assuming that their therapists are honest, ethical, law-abiding, confidential, and will offer assistance safely and without exploitation. The rest of the trust must be earned, by demonstrating that a client can speak openly about sensitive personal matters without being judged, harmed or betrayed by the therapist. My commitment is to remain trustworthy to my clients both on the scene and behind the scene. That is my word of promise to you in your treatment with me.

But more is required of me than my word of promise. Mental health services have become increasingly regulated by entities outside of the therapy office – professional associations, state laws and regulations, federal statutes, as well as insurance companies. Some of these entities require that I provide notification of the relevant rules and rights pertaining to mental health care.

My practice policy manual (available at [drkandle.com](http://drkandle.com), in my waiting room, and via paper copy by request) contains all the rights, rules, laws, ethics, policies, confidentiality requirements/exceptions, emergency procedures, financial terms, and complaint procedures that govern my practice of mental health care. I encourage you to examine these documents and to ask me about all issues you may have questions or concerns about. Most of these terms are for the protection of the mental health consumer, although some of them are also for the protection of the professional.

I, Michael R. Kandle, Psy.D., accept responsibility for fulfilling the implicit and explicit terms of trust outlined throughout my provider manual.

Your signature below, acknowledges that all of this information has been made available to you before your treatment has been initiated.

Sign \_\_\_\_\_ Date \_\_\_\_\_