STEVE FRANKLIN, M.S.W., L.C.S.W.

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Thank you for taking a few moments to complete this form. Feel free to ask any questions that come to mind.

Reason you are seeking services at this time: _____
_____

Client's Name: _____ Date of Birth: _____
Street:_____ _City_____ ZIP Code_____
Home Phone _____ Other Phone _____
Employer _____ Income _____
Education (circle highest level completed) Grade School High School College Grad School
Client's Marital Status _____ Number of Children _____
Other Significant Persons in Client's Life _____
_____
*In an emergency contact (Name/Phone)*_____
Have you ever had a psychiatric hospitalization?_____
Any Ongoing Medical Problems (Describe)?_____
Please list any medication you are currently taking (any medication allergies?)-_____
_____
Any current legal issues? _____
Many insurance companies ask therapists to contact Physician to coordinate care. Do you give permission for this? Decline☐ Agree ☐ Name of Primary Care Physician _____
(Your written authorization is required if you would like your therapist to speak or share reports with any other person)
Name of Psychiatrist, Counselor, or other Health Care Professionals you are working with:_____
_____
Have you been involved in therapy/counseling before?_____

Scheduling: Please call at least 24 hours in advance to cancel an appointment. You may be charged for appointments not kept or canceled without 24 hours notice.

Crises: If you feel an urgent need to talk between sessions, call me at 314-517-8383 ("51-STEVE"), and I will return the call as soon as possible. If the emergency is life threatening, call Life Crisis Services Hot Line (647-4357), Behavioral Health Response(800-811-4760), or "911".

Fees: The standard fee is $90 per hour, usually collected during each appointment. Special payment arrangements, such as a sliding fee scale, insurance reimbursement or delayed payment, may be negotiated with the therapist.

Privacy: I will adhere to all state laws and ethical standards. You can expect information from your counseling sessions to be kept confidential by me, unless: 1) You report information that a child appears to have been abused; 2) You express intent to kill or seriously injure yourself; 3) You express intent to kill, seriously injure, or commit a crime against someone else; or 4) You report unethical behavior by another therapist. Information about your therapy may also be subpoenaed by a court of law, although our right to maintain client privilege (confidentiality) has been upheld by the Supreme Court. Your case may also be discussed for the purposes of clinical consultation with other therapists. You may also give me written authorization to discuss your case with any one else you choose.

*A full **Notice of Privacy Practices** and **Standards of Communication** are posted in my waiting room and on my web site, or can be printed upon request.*

Case Closing: If there is no session or communication with the therapist for a period of 6 months, the case will be closed. Therapy may be later be resumed by mutual agreement.

I have read and understand the above._____ _____
Client Signature Date