Valerie Sher, Ph.D.

Licensed Psychologist, PSY23292
408-507-4329

Today's Date: _____

Couples Contact Information

PATIENTS

Name (Last, First, Middle) _____
Gender:_____ Age:_____ Birthdate:_____
Address:_____
_____
Home Phone: _____ Work: _____ Cell:_____
Email: _____

Name (Last, First, Middle) _____
Gender:_____ Age:_____ Birthdate:_____
Address (if different than above):
_____
_____
Home Phone: _____ Work: _____ Cell:_____
Email: _____

ETHNICITY/LANGUAGE

What ethnic background do you identify with? _____
Primary Language: _____

EMERGENCY/PROVIDER

Emergency Contact: _____ Phone: _____
Primary Care Physician: _____ Phone: _____
Psychiatrist: _____ Phone: _____

Additional Significant Information (other current health services, family members, significant others, conservator, guardian, probation officer, private therapist):

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During your first session, your therapist will discuss several important issues with you. This form will help acquaint you with the nature of our services. Please ask for clarification around any issue that may concern you.

STATUS OF THE THERAPIST Your therapist, Valerie Sher, Ph.D. is a psychologist licensed to practice in California (PSY 23292).

CONFIDENTIALITY In accordance with California law, the information disclosed by you in therapy is confidential and is not released or accessible to anyone without your written permission. By law the following exceptions apply and may require that relevant information is given to others:

(1) danger to self; (2) danger to others; (3) when a child, disabled person, or elderly person is physically abused, sexually abused, or neglected; (4) when a court of law issues a legitimate subpoena; and (5) when a collection service is required for unpaid bills.

IN CASE OF EMERGENCIES If you cannot reach me directly please leave a message and I will return your call as soon as possible. I check my messages frequently Monday through Friday. I will make every effort to return your call on the same business day. If you call in the evening or on the weekend, I may not be able to return your call as promptly. I will do my best to return urgent calls. If the call is not urgent, I will return it the next day or on Monday. If you are in crisis and sense that you that you can't wait for me to return your call, go to the nearest emergency room and ask for the psychiatrist on call, or call the Santa Clara Suicide and Crisis Hotline at 650-494-8420. If I will be unavailable for an extended time, a colleague of mine will be available for you to contact.

PAYMENT OF SERVICES (Please initial)

____ I agree to pay in full for services rendered by my therapist.
____ I understand that my fee is _____ for a 50 minute session, or ____ for each 2 hour group session, and that extended or non-emergency phone therapy will incur a prorated fee.
____ I understand that I must make cancellations of therapy appointments 48 hours in advance, and that I will be charged for missed appointments or cancellations less than 48 hours in advance.
____ I understand that basic information necessary for record keeping of appointments, payments, diagnosis, address and telephone, and any other information required for insurance billing will be released to our insurance billing service. Please call me with any billing questions.
____ I understand that any uncollected bills for services or missed appointments may result in disclosure of my name, telephone number, SS#, and address to a collection agency or small claims court. I also understand that I am responsible for any bills that my insurance does not reimburse.

TREATMENT OUTCOME There are no guarantees that treatment will be successful, although most clients do make significant progress. The length and outcome of treatment is based upon your motivation for treatment, how long you have had symptoms, the skill of the therapist, and other factors.

I HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE AND HAVE RECEIVED A COPY OF THIS INFORMATION

_____ _____
CLIENT DATE

_____ _____ _____ _____
CLIENT DATE THERAPIST DATE