

CONFIDENTIAL CLIENT INFORMATION FORM GENERAL 2018

Colleen Russell, LMFT, CGP
Licensed Marriage and Family Therapist (MFC29249); Certified Group Psychotherapist (41715)
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Name: _____

Date: _____

Street Address: _____

City, State, Zip: _____

Date of Birth: _____ Telephone: (H) : _____ (W): _____ (Cell): _____

Email: _____

Emergency Person and Number to Call: _____

Referred By: _____

Previous/Current Psychotherapy or Counseling From: _____ To: _____ Therapist(s)' Name(s)

Was your experience in therapy positive? Briefly explain: _____

Medical Information: (Past and Current Medications and dosages, Conditions):

Single ___ Married ___ Partnership ___ Divorced /When? ___ Bereaved/When? ___

How Long in Current Relationship? _____ Partner's Name: _____

Children? Ages:

Occupation and Position or Current Enrollment in School:

Highest Education: _____ Degree: _____ Subject: _____

1 What major losses have you experienced, and When?

What brings you to therapy or counseling, individual, couple, family, or group?

What strengths do you have?

Superbill if requested:

I will provide a “Super Bill” that you can send to your insurance company so you may get reimbursement for our sessions since I have opted out as an insurance provider so I can spend more time with clients. Payment is required at the time or prior to services received. I can’t guarantee your insurance will reimburse you, nor do I know for what amount. It is your responsibility to ascertain this information.

Fee: We have agreed on a fee of \$150.00 private pay for the consultation/initial session or continuing sessions.