CREATIVE DEPTH PSYCHOTHERAPY

Seja Rachael MA, LPCS
1310 South First Street #200 78704

Name_____ Date of first visit_____

Age _____Date of Birth_____

Address:_____

Phone: Primary: _____ Leave a message? Yes_____ No_____

Alternate # _____ Leave a message? Yes ____ No_____

May we email you? No___ Yes___ Email_____

Referred by_____

Occupation:_____Employer_____

Psychiatrist: Name _____Phone_____

Address_____

Current Medications _____

Taken for:_____

Previous psychotherapist_____

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Pertinent health information :

In case of emergency notify:_____

Relationship to you: _____ Telephone:_____

Please describe what prompted you to make this appointment?

What have you tried to address your concerns?

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Services Provided and Payment and Policy Information:

Individual psychotherapy 125.00

Relationship therapy 160.00

Group Therapy 55.00

Appointments not cancelled at least 24 hours in advance will be billed in full. Fees are due and payable at the end of each session.

I am not available on an on call emergency basis. I will return the call within 24 hours unless otherwise notified.

Email and text correspondence are not considered to be a confidential medium of communication. My preference is to limit Email and texting. Although, Alice Smith, my scheduling clerk will utilize encrypted email with your consent.

Please feel free to discuss any of these policies with me before or during your time in therapy. Your signature below indicates that you have read, understood, and agree to abide by these policies.

A copy of this document will be provided to you upon request

I agree to the terms and conditions mentioned above:

Signature: **Date:**

_____ _____