

Ellen R. Hoffman, MA, LPCC, LLC
Individual, Family, and Group Counseling

12417 Cedar Rd., Suite 23
Cleveland Heights, Ohio 44106
ellen@ellenrhoffman.com
ellenrhoffman.com
(216) 245-7440

Name: _____ Date _____
Home Phone _____ Work phone _____
Cell Phone _____ Email Address _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____
Gender _____
Pronouns _____
Name of person who referred you to me: _____

Contacting You – Information

In an effort to protect your privacy, when contacting you I will identify myself by my name only and not by my position as a psychotherapist. That stated:

May I contact you at work if necessary? (Circle One) Y N
May I leave a message on your voicemail?
At home? (Circle One) Y N
At work? Y N
On your cell? Y N
May I email you? Y N

Please comment on any restrictions to the above:

In case of clinician illness or emergency, where may I call to cancel our same day appointment? _____

Emergency Information

In case of emergency, contact:

Name _____

Relationship to client _____

Telephone:
(Home) _____ (Work) _____

(Cell) _____

Address (Street, City, State, Zip): _____

Medical Information

Physician name: _____

Physician phone number: _____

Psychiatrist name (if applicable): _____

Phone _____

Current Medications:

INTAKE INFORMATION

Reason you (or your child/adolescent) are coming to therapy:

Have you (or your child/adolescent) been in therapy before? How did it go?

Please give a brief account of your current living situation (who you live with, etc, and any information you think is relevant)

Please tell me anything else you think is important for me to know about your situation before we meet.

Payment and Health Insurance

Please Read Carefully! I handle health insurance differently than many health care providers. My services may be covered by your policy's provision for "out of network" mental health providers.

I ask my clients to pay for services directly at the time of service. I do not accept direct assignment from insurance carriers. Payment may be made by check, credit card, HSA, or in cash.

My role will be to assist you in any reasonable way possible so that you can submit to your insurance carrier for "out of network" coverage if you choose this option.

Ellen R. Hoffman, MA, LPCC, LLC

PROFESSIONAL SERVICES AGREEMENT

Ohio regulations require that all clients are fully informed regarding the costs of professional services. Following is a list of fees and a summary of my billing practices. I ask that you read this material carefully, and sign below to signify your acceptance of these terms.

FEES:

Initial Consultation	\$175
Office visit (50 minutes):	\$150
Office visit (75 minutes):	\$185
Office visit (90 minutes):	\$225
Telephone Consultation	Office visit rate, pro rata
E Mail Consultation	Office visit rate, pro rata
Other time/services	Office visit rate, pro rata

Payment is expected in full at the time of the office visit.

Twenty four (24) hour notification is requested for all cancellations of appointment time reserved. If you anticipate even a potential problem keeping a reserved appointment, please call to let me know. Should you cancel with less than 24 hours notice, I will do my best to fill the appointment hour. If I am unable to do so, you will be responsible for the full fee for the time reserved.

Emergencies:

In an emergency, call 911 or go to your nearest emergency room.

I have read and understand the above, and accept full financial responsibility for fees incurred within the framework of this agreement.

I have received and read the Notice of Privacy Practices Form.

Your name (Please print)

Your Signature and today's date

Please Detach This Page and Keep for Your Records

Ellen R. Hoffman, MA, LPCC, LLC

PROFESSIONAL SERVICES AGREEMENT

Ohio regulations require that all clients are fully informed regarding the costs of professional services. Following is a list of fees and a summary of my billing practices. I ask that you read this material carefully, and sign below to signify your acceptance of these terms.

FEES:

Initial Consultation	\$175
Office visit (50 minutes):	\$150
Office visit (75 minutes):	\$180
Office visit (90 minutes):	\$225
Telephone Consultation	Office visit rate, pro rata
E Mail Consultation	Office visit rate, pro rata
Other time/services	Office visit rate, pro rata

Payment is preferred in full at the time of the office visit.

Twenty four (24) hour notification is requested for all cancellations of appointment time reserved. If you anticipate even a potential problem keeping a reserved appointment, please call to let me know. Should you cancel with less than 24 hours notice, I will do my best to fill the appointment hour. If I am unable to do so, you will be responsible for the full fee for the time reserved.

Emergencies:

In an emergency, call 911 or go to your nearest emergency room.

I have read and understand the above, and accept full financial responsibility for fees incurred within the framework of this agreement.

I have received and read the Notice of Privacy Practices Notice Form.

Your name (Please print)

Your Signature and today's date