Dara Weil, PsyD, LLC

Licensed Clinical Psychologist

600 Davis St.
Suite 3E
Evanston, IL 60201

Phone: 312-458-9258 x2
Fax: 847.328.4838

Name ______________________________________ Date _______________

Birthdate _____________ Age _________ Social Security # _________________

Address ____
(street) (city) (state) (zip code)

Responsible Party (if different from above) – statements will be sent to this address

Name _____________________________________

Address ____
(street) (city) (state) (zip code)

Phone number ____________________

To (re)schedule appointments, where may I call?

Home ________________ Work _______________ Cell ________________

May I leave a message on the answering machine? Yes _____ No _____

May I leave a message with someone at this number? Yes _____ No _____

Who may I contact in case of an emergency?

Name ______________________________________

Address ____
(street) (city) (state) (zip code)

Phone number _____________________ Relationship to you ________________

Please complete the following:

Marital Status _____________ Ethnic Identity: _______________

Briefly describe your reason(s) for seeking services:

____

____

Have you ever had previous counseling or psychotherapy*?* Yes _____ No _____

If "yes," by whom and when? ____

Have you ever been hospitalized for a psychiatric reason? Yes _____ No _____

Have you ever made a suicide attempt/gesture? Yes _____ No _____
Who may I thank for this referral?________________________________

Please use the scale below to indicate your current level of distress on the following items:

	No concern		Moderate	Urgent
Feelings over a recent death/loss	0	1	2	3
Relationship with friends or family	0	1	2	3
Relationship with romantic partner	0	1	2	3
Sexual concerns	0	1	2	3
Sexual orientation	0	1	2	3
Survivor of abuse	0	1	2	3
Racial/Ethnic issues	0	1	2	3
Low self-esteem	0	1	2	3
Loneliness	0	1	2	3
Depression	0	1	2	3
Anxiety/Fears or worries	0	1	2	3
Sleep problems	0	1	2	3
Eating problems	0	1	2	3
Body image concerns	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Losing contact with reality	0	1	2	3
Suicidal feelings/behavior	0	1	2	3
Fear of endangering others	0	1	2	3

Authorization for release of information for billing purposes

I hereby authorize the release of any information necessary for third-party submission and/or payment for services. I authorize payment of third-party benefits to Dara Weil, PsyD for services described herein.

________________________ ________________ ____________________
Signature of Client Date Witness

Consent To Treatment

I acknowledge that I have received, read, and understand the "Statement of Patient Rights and Confidentiality" sheet. I do hereby seek and consent to participate in treatment by this therapist.

I am aware that the development and review of the progress, or of a Treatment Plan is in my best interest and may be required by government, funding, accrediting, or other agencies and I agree to actively participate in this process.

I am aware that the practice of psychotherapy or counseling is not an exact science and so predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by this agency.

I am aware that I may terminate my treatment at any time without consequence, but that I will still be responsible for payment for the services I have received.

I am aware that any cancellations of appointments must be made more than 24 hours in advance of the appointment and if I do not cancel or do not show up, I will be charged for that appointment. I understand that the charge for a missed appointment is $120.00.
Any payments that are later than 30 days of due date will be subject to a $20 late fee and 6% interest for every day that it is late. I also understand that I will be responsible for services rendered which are not covered by my insurance plan.

_______ Please initial that you read and understand this

I am aware that an authorized agent of my insurance carrier or other third-party payer may request and be provided with information about the type(s), cost(s), date(s), and details of any services of treatment I receive here, so that payment may be provided to the therapist.

I am aware that if I have not paid for services received, my treatment may be discontinued by my therapist.I am aware that this office or therapist is not responsible for any personal property or valuables I bring into its facilities.

I certify, with my signature below, that I have read, had explained to me where necessary, fully understand, and agree with the content of this Consent to Treatment.

_______________________ _______________ ____________________
Signature of Client Date Relationship to client (if necessary)

______________________ _____________
Witness Date

STATEMENT OF CLIENT RIGHTS AND CONFIDENTIALITY

1. You have the right to treatment, regardless of race, religion, sex, ethnicity, age, or handicap.
2. You have the right to determine who will provide treatment for you and you have the right to decide not to receive psychotherapy from me. If you wish, I will provide you with the names of other qualified professionals.
3. You have the right to terminate therapy if so desired. I request that you discuss your desire to terminate treatment face to face so we can process you feelings and provide closure.
4. You have the right to ask questions at any time about the therapeutic process and interventions utilized.
5. You have the right to be treated with dignity and respect.
6. You have the right to receive individualized treatment including a verbal discussion of treatment goals and plans.
7. You have the right to know the cost of services rendered.
8. You have the right to receive a written statement of your rights.
9. You have the right to have the information discussed within our sessions remain confidential. Generally, no one will learn of our work without your specific, written permission. There are some exceptions to this however. If you would like your insurance company to reimburse for your therapy, then you must be willing to allow information about your treatment, such as treatment goals, prognosis and diagnosis, and progress, to be shared with the insurance company and/or gatekeeper organization. In addition, there are some situations in which I am required by law to reveal some of the information you tell me, even without your permission. These situations are as follows:
    a) If you seriously threaten to injure another person, I must tell that person and the authorities.
    b) If you are at risk to harm yourself.
    c) If you reveal information pertaining to either child or elder abuse.
    d) If a court subpoenas me to testify about you.

10. You have the right to be protected from physical, sexual, and other abuse.
11. You have the right to be informed of your progress.

________________________ _______________ ________________________

Client Name Date