_______________*Dr. Melissa Cordero*___________

Initial Information Form

Date:

Name: ____Pronouns____________________________

Address: ____

City, State, Zip: ____

Date of birth: ____________________

Gender___________

Sexual Orientation________________

Phone: Cell ________________________________ OK to leave a message? Y N

Email ________________________________

Employer: ____

Position: ____

Address: ____

Spouse (or parent if minor): ____

Date of birth: ____________________

Emergency contact name: ____

Phone number(s): ____

Primary physician: ___________________________________ Phone: ____________________

List any significant health problems: ____

____

List any medications you are presently taking and the dosage:

____

Have you been in therapy before? Yes ____ No____ If yes, when? ______________________

Name of therapist: ____

Reason for coming to therapy now, in your own words:

____

____

____

Referred by (circle one): **Friend** **Web site** **Insurance** **Other referral**

_______________*Dr. Melissa Cordero*___________

INFORMATION ABOUT YOUR THERAPY

CONFIDENTIALITY:

All information shared in a therapy session is confidential except in circumstances governed by the laws, including the mandatory reporting of alleged harm to self or harm to others, particularly in the case of child, handicapped person or elder abuse. You may also waive your right to confidentiality in writing, should it be beneficial to you that I, as your therapist, contact someone on your behalf.

CONTACT INFORMATION:

Messages can be left at any time at (310) 913-9773, and I will return your call personally within 48 hours during the business week. For emergencies, please call 911.

FINANCIAL AGREEMENT:

The fee for a 50 minute session is $195. Fees are due at the end of each session.

INSURANCE:

I am currently only on MHN. If you are on another insurance panel, you can bill out of network and request a reimbursement of payment provided at your out of network cost. I will provide a bill after each session for you to submit to your insurance company if you request this.

CANCELLATION POLICY:

Your appointment time is reserved exclusively for you. **Twenty-four hour notice is required for cancellation of a scheduled appointment or there is a charge of the usual session fee of $195.** *As a courtesy I would appreciate at least a 48 hour notice of a change in your appointment time.*

THERAPEUTIC WORK

Your feedback is important and always welcome regarding our therapeutic work together. If at any time you do not find it to be meeting your needs and expectations I encourage your direct discussion so that your concerns can be addressed immediately. And, I reserve the right to terminate the therapeutic relationship if after discussion and/or confrontation it becomes clear that our work is not providing you with needed assistance.

I have read and understand this information sheet and I am agreeable to its terms and conditions. For insurance only: I authorize the release of any medical and other information necessary to process an insurance claim(s), including electronic claims, obtain authorization(s), comply with an insurance audit or other matters related to my health plan. I authorize insurance payment to Melissa Cordero, Psy.D. for psychotherapy services.

_______________________________________ ____________________

CLIENT (OR PARENT/ GUARDIAN FOR MINOR) DATE