

APRIL V. MORAN, LCSW-C, MSW, ACT
2324 W. Joppa Rd. STE. 220
Lutherville, MD 21093
Phone: 410 583-2622
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Email: aprilvmoran@icloud.com

Date _____

Client Name _____

Date of Birth _____ Home phone _____ Cell Phone _____

Email address _____

Address _____ City _____ Zip code _____

Marital Status _____ single _____ married _____ divorced _____ widow(er).

Primary Care Physician and phone # _____

Permission to confer with your primary care physician? Yes/No

Referred by _____ Permission to send an
acknowledgement of your referral to the referral source? Yes/No

Responsible Party – Who is responsible for the account?

Name _____ Relationship to client _____

Address _____

City _____, State _____, Zip _____

Phone # _____ Employer _____

Occupation _____

In case of emergency, who should be notified?

If client is a minor, Parent/Guardian must fill out.

Name _____, Relationship _____

Phone # _____ Email _____

FINANCIAL POLICY

Cancellation Policy: I understand that twenty-four-hour notice must be given for cancelled appointments or I will be responsible for the full fee of the missed appointment. This fee will be paid before any further appointments are made. I understand I am responsible for submitting my own insurance claims for reimbursement. I give permission for April V. Moran to release otherwise confidential information to my insurer or managed care company so that I can seek reimbursement. All fees are due at the time of service.

Signature _____

CONSENT TO TREATMENT

I give permission and consent to April V. Moran, LCSW-C to provide psychotherapeutic services. Services may include initial evaluation, with myself, members of my family and psychotherapy. While I expect benefits from treatment, I fully understand the desired benefits and particular outcomes cannot be guaranteed. I understand that regular attendance and full effort and participation through doing assignments will produce the maximum benefits, but that I am free to discontinue treatment at any time. I know of no reasons why I/we should not participate in treatment This consent will apply to myself, and if applicable, _____ who is my child and for whom I have legal custody and power to consent for mental health treatment.

Signature of Client or Parent/Guardian _____
