APRIL V. MORAN, LCSW-C, ACT
1122 Kenilworth Drive, suite 100
Towson, MD 21204
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?

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_____
