LISA FRANKEL, Phd MFT : 310 398-9385: ***drfrankel@yahoo.com***

CLIENT INFORMATION FORM

Today's Date: _______________Date of Birth:_________ Social Security Number:_________ E Mail: ___________

Full Name: ________________ Cell Phone:_____________Home: ___________ Work: _______Best number to contact you?

Home Address:____ ________

Employer:_________________________Employer's Address:________________________________

Insurance Company & Type:_____________________ Insurance phone:__________ Policy #: ____________ Group Number:____________ Deductible still owed: ________ Co-pay amount?____

Person Insured: __________ Insured DOB: _________Employer:________________ Address________________

Primary Care Physician: (name and phone number) _________________________________

Psychiatrist? (name and phone number) _________________Other Medical Professional: ___________________

Medical or Psychiatric conditions you are being treated for: ____

Current Medications: Name & dose, MD prescribing:____ _________________ ______________________ ____

Significant Medical History: ____

Use of alcohol? How frequent: ______________________Marijuana or CBD? ____________ Other drugs? _____Do you or a significant other think it is interfering with your life?

Do you have a problem with over-eating, restrictive eating, or purging? ________________________________

Other habits or behaviors you think may be creating a problem in your life: (ie:exercise, gambling, sex addiction computer use, shopping?)____

If any of these statements are happening now: ***Please talk with me Immediately:***

**Are you currently in danger of hurting yourself ? Someone else?*

**Are you currently in a situation where you are being abused verbally, physically sexually or emotionally?*

**Are you currently in a situation where you are in danger in any way?*

**Are you currently in a situation where a child or elder is being abused or neglected? *

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Name of Partner/significant other:_______________ Phone number:__________________ Length of relationship:__________ Past significant partner relationships

Children: Yes___ No___ Ages: __________

***Mother's** Name__________Age: _________If deceased, age and cause of death?__________________*

Father's Name: _________Age: _________If deceased age and cause of death?__________________

Siblings: Names, ages:____

Any other significant family members or important figures in your life: ____________________

Other support systems? ________________________________

History of drug or alcohol abuse or mental illness in your family? _______________________________

____

Are you involved or do you anticipate being involved in any legal case which would require therapist involvement? Please let me know immediately if you are. If you are looking for therapist involvement in a case, this is not my expertise, and I will give you references

History of Psychotherapy/Counseling:

Name of Therapist: Dates Reason for termination

Current reasons for seeking therapy?
____

Symptoms / issues that are creating problems in your life?
____

Please indicate problem areas severity and length of time.

Problem area Severity (1-mild 2.moderate 3. severe 4. Very severe) How Long? Comments?

Job/School

Family

Partner/Significant Other

Other Relationships

Self: emotional life/ quality of life

List 4 goals for therapy:

LISA FRANKEL, PH.D MFT License # 13260 drfrankel@yahoo.com

2990 Sepulveda Blvd # 203 310 398-9385

Los Angeles, Ca. 90064

AGREEMENT FOR EXCHANGE AND /OR RELEASE OF INFORMATION

I hereby authorize Lisa Frankel, PH.D MFT to exchange, and/or release clinical information with the individual or agency licsted below:

Name:____

Address____

City____State__________Zip_________

Telephone: ________________________Email: ________________________

Dr Lisa Frankel will observe applicable rules of confidentiality regarding any information written or verbal that is received under this agreement. It is understood that this exchange and/or receipt of information is intended for the purpose of furthering treatment.

Client Name -Print:_________________________Signature: __________________________Date______________________

Client Name – Print_________________________Signature:__________________________Date: _____________________

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INSURANCE VERIFICATION INFORMATION FORM

I am a provider for Cigna and Aetna insurance. Before you come in for the first session, please call your insurance company and confirm that I am a provider, and find out the following: How much is your deductible if you have one, and how much has been met? How much is your weekly co-pay? How many authorized sessions? Do you have EAP sessions that you will be using first? Other funds that cover fees?

Please fill out the following information regarding your insurance. If the insurance is not through your employer (ie: if you are covered under the insurance of a parent or partner) please indicate their address, phone, employer and birthdate as the Person Insured.

Today's Date

Name of Patient DOB

Name of Insured Relationship to Insured DOB

Address of Insured Phone Number

Employer of Person Insured:

Insurance Company Insurance Company Servicing Mental Health

Type of Insurance (PPO, POS, HMO or other) Insurance Number
Group Number

Deductible How much of the deductible has been reached? Weekly co-pay

If authorization is required, have you called to get therapy authorized?

Number of visits authorized through insurance: Expiration of Authorization.

*IF you are insured by a company other than Cigna or Aetna, please let me know if they cover Out of Network, and I will give you a monthly Superbill that you can send in on-line or by mail.