DONNA GOLD, LCSW

Psychotherapist Specializing in Trauma Survivors

Courage • Compassion • Connection

PATIENT INFORMATION

Date ____/_____/_______ **DOB** ____/_____/_______ **Age** _____ **SS#** _____-_____-_________ **DL #** __________

Name ____ Male Female Other _______

Phone (cell) (_________) ______________________________________ Okay to leave message? Yes No

Phone (work) (_________) ______________________________________ Okay to leave message? Yes No

Phone (home) (_________) ______________________________________ Okay to leave message? Yes No

Email Address ____

Address ____

City ____________________________________ **State** __________ **Zip** ______________________

Emergency Contact ___________________________ **Relationship** ___________ **Phone** (_____) ___________

Patient's (or guardian) employer & address ____

Name of spouse (or guardian if a minor) ____

Marital Status Married (If married, how many times? _____) Domestic Partnership Single

Divorced (If divorced, how many times?_____) (Separated Other (___________________)

FAMILY HISTORY

Who do you live with? ____

Children's names and ages____

____

Parent's names and ages ____

____

Ethnicity ___________________________ **Religion, if any** _____________________________

MEDICAL HISTORY

Personal Physician and Contact Info ____

____

Psychiatrist or Other Medical Providers and Contact Info ______________________

____

Donna M. Gold, LCSW | LCS 28494 | Phone (858) 227-9182 | Fax (858) 227-9477
11835 Carmel Mountain Road | Suite 1304, PMB 153 | San Diego, CA 92121 | www.donnamariegold.com | donnamgold@gmail.com

Current Medications and Dosages (Include non-prescription) ______________________________

____

Medical illnesses / Diagnoses: ____

Drug allergies: ____

Additional allergies: ____

Date of last medical exam ______________ Results ______________________________

Do you use drugs? __________ Frequency? ______________________________________

Type(s) ____

Do you drink alcohol? __________ Frequency? ___________________________________

Type(s) ____

Do you smoke cigarettes? __________ Frequency? _________________________________

Have you had mental health treatment before? ____________ When? _________________

____

With whom, where and why? ____

____

What brings you to therapy now? _____________________________________

____

What else would you like me to know? __________________________________

____

What would you like to achieve in therapy? ______________________________

____

Who referred you to me? ____

Employment Status: Employed Full-Time Student Full-Time Other ______________

Employed Part-Time Student Part-Time ______________

Highest Level of Education: Middle School/Jr High Some High School Gradated High School

❑ Some College/Technical School ❑ Graduated Technical School/Trade School ❑ Associates Degree

❑ Bachelor's Degree ❑ Master's Degree ❑ Doctorate Degree ❑ Other ______________

Gender: ______________________ **Sexual orientation:** ______________________

Donna M. Gold, LCSW | LCS 28494 | Phone (858) 227-9182 | Fax (858) 227-9477
11835 Carmel Mountain Road | Suite 1304, PMB 153 | San Diego, CA 92121| www.donnamariegold.com | donnamgold@gmail.com

RESPONSIBLE PARTY FOR BILL

ALL clients must complete the following section even if utilizing insurance. SHOULD YOUR INSURANCE COMPANY NOT COVER THE COST OF YOUR SESSION(S), YOU WILL BE RESPONSIBLE FOR PAYMENT.

Name ______________________________ **Relationship to patient** ________________

Address __________________________ **City** ________________ **State** ____ **Zip** ________

Social Security Number ________-________-________ **Date of Birth** _____/_____/ _____

Employer ____

Employer's Address ______________________________________

City ____________________ **State** _____ **ZIP** __________ **Work Phone**: (____) ________

INSURANCE COVERAGE:

Do you have MediCal? Yes No

Do you have MediCare? Yes No

Name of Primary Insurance Company ______________________________

Name of Insured ______________________________

Relationship of Insured to Client (if it is you, just put "self") ______________________________

Subscriber ID/Member Number ____________________ **Group Number** ________________

Insurance Contact Number ______________________________

Name of Secondary Insurance Company ______________________________

Name of Insured ______________________________

Relationship of Insured to Client (if it is you, just put "self") ______________________________

Subscriber ID/Member Number ____________________ **Group Number** ________________

Insurance Contact Number ______________________________

Donna M. Gold, LCSW | LCS 28494 | Phone (858) 227-9182 | Fax (858) 227-9477
11835 Carmel Mountain Road | Suite 1304, PMB 153 | San Diego, CA 92121 | www.donnamariegold.com | donnamgold@gmail.com

ALL clients must complete the following section even if utilizing insurance. SHOULD YOUR INSURANCE COMPANY NOT COVER THE COST OF YOUR SESSION(S), YOU WILL BE RESPONSIBLE FOR PAYMENT.

I understand I am responsible for full payment due at the beginning of each session, and I should contact my insurance company to gain a better understanding of my out of pocket expenses for services provided by an "out of network" provider. **I understand that I am responsible for all charges, regardless of insurance coverage, and for missed appointments or cancellations with less then 24 hours notice.** I understand I am responsible for seeking reimbursement through my insurance if I have insurance. I authorize this office to release any information necessary to expedite insurance claims if applicable. A copy of this signature is valid as the original.

Name as it appears on card: ______________________ Card Type (Visa, MC, AE): ____________

Account Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Expiration Date: __ __ / __ __ __ __

CVV Code (on back of card): ___ ___ ___ Billing zip code: ___ ___ ___ ___ ___ – ___ ___ ___ ___

Cardholder Signature: ______________________________ Date: ________________

AUTHORIZATION FOR PAYMENT (ALL CLIENTS): I authorize Donna Gold, LCSW to charge my credit card for any unpaid fees including:

- Fees for services (therapy session)
- Missed appointments that are not canceled with at least 24 hours advanced notice

This authorization is ongoing and will be automatically revoked six months after the last date of service. Until that time, I authorize payment as described above to Donna M. Gold, LCSW. I understand that this six-month time period may be required to determine final amounts due and settle my account; and that my credit card may be billed during this time. Expiration or cancellation of a credit card does not relieve me from any unpaid debt. I also agree that I will be charged $5 for payments processed over the phone.

Initial intake sessions are always 60 minutes. The fee for a 60-minute sessions is $160, and the fee for a 45-minute session is $120. Payment is due at the time service is rendered unless special arrangements are made.

The hour for your appointment is reserved strictly for you. If you cannot make the appointment, please call to cancel 24 hours in advance or you will be charged a missed appointment fee of $120. There are no exceptions to this policy.

MediCal & EAP Clients ONLY: Missed appointments or late cancellations are costly to the therapist and deny other individuals the opportunity to use that time. All cancellations must be made at least 24 hours in advance. Though you will not be charged if you fail to give 24 hours advanced notice of a cancellation, **three cancellations or no-shows will result in being terminated as a client, and you will receive a referral to another therapist.**

Signed: ______________________________ Date: ________________

Donna M. Gold, LCSW | LCS 28494 | Phone (858) 227-9182 | Fax (858) 227-9477
11835 Carmel Mountain Road | Suite 1304, PMB 153 | San Diego, CA 92121 | www.donnamariegold.com | donnamgold@gmail.com

CONFIDENTIALITY: Communication between patient and therapist is privileged except child, elder or dependent abuse and/or a threat to the life of another person. If you have managed health care, their utilization review panel will be involved. Confidentiality law binds them.

RELEASE OF INFORMATION: This form must be signed and approved by you if you wish that records or information go out of the office except to your insurance/managed care provider.

ALL CLIENTS:

I consent to assessment and treatment under the care of Donna M. Gold, MSW, LCSW.

I have read, understand, and agree with the above stipulations.

Signed: ________________________________ Date: ________________

Signed: ________________________________ Date: ________________

Donna M. Gold, LCSW | LCS 28494 | Phone (858) 227-9182 | Fax (858) 227-9477
11835 Carmel Mountain Road | Suite 1304, PMB 153 | San Diego, CA 92121| www.donnamariegold.com | donnamgold@gmail.com