Dr. Robyn Zeiger

Client Questionnaire

Fees and Payments

1. My standard fee for individual and couples counseling is $180/45 minute session.

2. I have a limited number of sliding scale slots at a minimum of $110/45 minute session for individual counseling; the minimum for couples is $120/45 minute session.

3. The fee for group counseling is $80 per group (1½ hours in length). There is no sliding scale for groups – all group members pay the same fee.

4. I will charge my regular fee for telephone consultations extending beyond five minutes on a prorated hourly basis. Such consultations include talking with the client as well as collaterals (e.g., parents, physicians, therapists, lawyers, etc.).

5. Written reports to other professionals and agencies (including insurance companies) will be billed at a rate of $170/hour.

6. I will charge my regular fee for security clearance investigation interviews.

7. A service charge of $30 will be assessed for each check returned for insufficient funds.

8. I prefer that you pay your bill at the end of each session. However, if arranged beforehand, you may pay on a monthly basis. In any case, your account must be paid in full by the 20th of the month, as I strongly believe that the accumulation of debt interferes with the counseling process.

9. Methods of payment accepted are checks, money orders, cash, post-dated checks, VISA, MasterCard, and Discover.

10. Many insurance providers will cover my services, but please note that I am a Licensed Clinical Professional Counselor (State of MD #LC0043) and Licensed Professional Counselor (District of Columbia #192 and State of West Virginia #932). I am not a psychologist or social worker - some health insurance providers only cover the latter two. I will submit a statement to you at the end of the month – please send this statement along with your completed insurance claim form to your insurance provider. Please remember that you will be responsible for whatever amount that your provider does not cover. If a deductible needs to be met, you must pay that as well. I prefer that you pay the entire $170 after each session, but if not possible, you can pay your portion and I will wait for the health insurance provider's payment. If this is the agreed upon method of payment, it will be necessary for you to sign "Authorization to Pay Provider" on your insurance claim form. Please remember that YOU are ultimately responsible for full payment for my services.

11. I am a "non-participating" CareFirst BlueCross/BlueShield provider. As I am sure you are aware, dealing with insurance companies has become increasingly difficult. The professional demands on my time do not allow me to submit insurance claims for you. You must deal with your insurance company directly.

12. If you are paying a reduced fee, I ask that you periodically reevaluate your financial situation. If you are in a position to increase the fee, especially if we have reduced the frequency of sessions, please let me know. If you need to lower the fee due to financial hardship, please discuss this with me as well. I feel that it is of the utmost importance for us to keep the lines of communication open – especially with regard to fees, payments, etc.

Appointments, Cancellations and Parking Information

1. I see your involvement in individual and/or couples counseling as a serious undertaking, involving important commitments from both of us. When your appointment has been scheduled, that time is reserved only for you. Therefore, it is your responsibility to keep your appointment, or to notify me as soon as possible when cancellation is necessary. Please leave your message on the answering machine and I'll return your call if you request that I do so.

2. If you do not give at least a 24-hour notice you will be charged for the missed session-no exceptions to this (other than inclement weather with dangerous road conditions).

3. If possible, I like to set up "standing" appointment times.

4. Please park on the parking pad in the driveway if space is available. You may also park on Sweetbriar Parkway after 5 p.m., Monday through Friday, and anytime on Saturday. Please do not park directly in front of the garage door.

5. Please try to arrive close to the time of your appointment and wait in the waiting area. There is no need to knock or ring the bell - I will meet you there.

After your session, please leave the parking area quickly so that we may free up spaces for other clients.

Group Counseling

1. The fee for group counseling is $80/group session (1½ hours in length), once a week.

2. Since your space in the group is reserved for you and cannot be filled in your absence, you will be charged the full fee –regardless of the circumstances. If you cannot attend a group session, please let me know so that I can inform the group members.

3. I prefer that you pay for your group session after each meeting.

Availability

1. When you call me, you will reach my answering machine. Please leave your name, telephone number with the area code, and a message.

2. I will return your call as soon as I can. If you call after 9:00 p.m., I will call you back the following day (my answering machine will tell me the time that you called).

3. Weekends- Whenever possible, please try to call me on week-days. However, if your message or concern is important to you, do not hesitate to call. Please be aware that it may take longer than usual to return your call since I check my machine infrequently on weekends. If you are unable to reach me during an emergency, please call the appropriate agency or service (e.g. 911, rescue squad, hotline, police, or hospitals). You can obtain any of these listings in your area by dialing 411 or online. If your question is related to your medication, please call your physician or psychiatrist.

4. Vacations, away for extended periods of time- If am away for more than three days, I will leave another therapist's name and number on the answering machine in case of emergency.

Miscellaneous

1. Since I value my privacy (I do work out of my home), please do not come to my office/home unless you have a scheduled appointment.

2. Since I am on the computer infrequently, please try to communicate via telephone versus the internet. Please limit emails to appointment information only (e.g., times, changes) and please no IM's! Please cancel appointments via telephone only!

3. If you schedule a couples' appointment, I will only see the couple, not an individual. If one person is unable to attend, we will need to reschedule and you will be charged for the appointment.

4. Please do not consume alcohol prior to your appointment or group meeting.

I HAVE READ AND CLEARLY UNDERSTAND THE POLICIES UNDER "INFORMATION FOR CLIENTS" AND AGREE TO ABIDE BY THE TERMS. I ALSO UNDERSTAND THAT SOME TERMS ARE SUBJECT TO CHANGE.

Signature _____

Print Name _____

Date _____

Check any of the following that pertain to you:

- ☐ Anxiety
- ☐ Nervousness
- ☐ Shyness
- ☐ Alcohol/Drug Problems
- ☐ Separation
- ☐ Anger
- ☐ Sleep
- ☐ Relaxation
- ☐ Memory
- ☐ Ambition
- ☐ Health-related Issues
- ☐ Relationships
- ☐ Alcoholic Partner
- ☐ Appetite
- ☐ Coming Out
- ☐ Child Abuse
- ☐ Grief
- ☐ You/Partner Having Affair
- ☐ Transgender Identity Issues
- ☐ Pet-Related Issues
- ☐ Depression
- ☐ Sexual Problems
- ☐ Breaking Up
- ☐ Self Control
- ☐ Stress
- ☐ Headaches
- ☐ Panic Attacks
- ☐ Legal Matters
- ☐ Energy Level
- ☐ Loneliness
- ☐ Education
- ☐ Alcoholic Parents
- ☐ Childhood Sexual Abuse
- ☐ Jealousy
- ☐ Stomach/ Bowel Problems
- ☐ Gambling Issues
- ☐ Aging Parents
- ☐ Gender Identity Issues
- ☐ Religious/Spiritual Issues
- ☐ Fears/Phobia
- ☐ Suicidal Thoughts
- ☐ Finances
- ☐ Friends
- ☐ Unhappiness
- ☐ Work-related Issues
- ☐ Fatigue
- ☐ Inferiority
- ☐ Insomnia
- ☐ Career
- ☐ Nightmares
- ☐ Temper
- ☐ Children
- ☐ Rape
- ☐ Learning Disabilities
- ☐ Shopping Issues
- ☐ Polyamory
- ☐ Toxic Parents
- ☐ Other _____

Client Questionnaire

Date

First Name **Last Name**

Street Address

City **State** **Zip Code**

Telephone:

Home Work

Cell Office

E-mail

Age **Birth Date**

Relationship Status

Married **Yes** **No**

Domestic Partnership Civil Union **Divorced**

Separated Widowed Other

If in a relationship, do you live with your partner? Yes No

What is his/her name? Name

Your Occupation

Education

Partner/Spouse's Occupation

Partner/spouse's Education

Do you have pets? Yes No

Briefly describe your reason for seeking help:

Who referred you to me?

When were you last examined by a physician? Date

Physician's Name

Physician's Phone Number

List any health problems for which you currently receive treatment:

List any medications you are now taking:

Have you ever received psychiatric counseling of any kind before? Yes ☐ No ☐

If yes, please explain:

If you believe insurance may cover a portion of your visits, please complete the following information:

Insurance Company:

Policy Number:

Group Holder:

If I ever need to contact you at work, may I do so? Yes ☐ No ☐

May I leave a message for you at work? Yes ☐ No ☐

Emergency Contact

Telephone

This is to certify that I give permission:

Robyn S. Zeiger, Ph.D., L.C.P.C., L.P.C. to provide counseling for myself and/or my child. I am expected to benefit from treatment, but there are no guarantees. Outpatient counseling does not have significant risks. Maximum benefits will occur with regular attendance, but I understand that I may feel temporarily worse while in treatment.

While under most circumstances, all communications between the client and the therapist is confidential, Maryland State Law mandates the reporting of actual or suspected child or elder abuse to the appropriate agency.

It has also been upheld that if individuals intend to take harmful or dangerous actions against themselves or others, it is the therapist's duty to warn family, significant others and/or the person who is most likely to suffer the result of the harmful behavior and to take appropriate protective action, if there is imminent danger.

Every reasonable effort will be made to appropriately resolve these issues or to notify the client before such a compromise of the client/counselor relationship is made.

I have the right to terminate the counseling relationship at any time that I should desire without fault.

I understand that I am financially responsible for this treatment and for any balance not covered by my insurance carrier.

A copy of this authorization shall be considered valid.

Signature of Responsible Adult _____ **Date** _____

Signature of Counselor _____ **Date** _____