



Diane M. Kohm, LMFT
Starlight Counseling

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Welcome and thank you for taking a few moments to complete this form. The next page will describe what to expect in our work together. At the end of that page, there is a place for your signature. If you wish, you can discuss the policies before you sign. Feel free to ask any questions.

Name _____ DOB & Age _____

Name _____ DOB & Age _____

Street _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Email _____ Mobile Phone _____

Email _____ Mobile Phone _____

Emergency Contact Name & Number _____

Employer(s) _____ Household Income _____

Education: (circle one) Grade School High School College Graduate School

Race/Ethnicity _____ Religious Preference _____

Marital Status _____ Name & Age of Spouse _____

Names & ages of Children _____

If you are currently receiving medical treatment for an illness or a chronic condition, or additional counseling for a personal or family problem, please describe the situation below:

If you are currently taking any medication, please list it below:

Name & Phone of Physician, Counselor, or Professional (Nurse, Physical Therapist, etc.) assisting you:

Who referred you to counseling or how did you find Diane Kohm? _____

Will you consent to Diane sending a thank you note to the referring person? _____

Insurance Company _____ Fee or Copay _____

Authorization Number _____ Authorized Visits _____ Deductible _____

Services: Include individual, couple, and family therapy for adolescents and adults. Referrals to medical, legal, or other services provided as needed.

Scheduling: Please call at least 72 hours in advance to cancel or reschedule an appointment. If timely notice is not provided, you may be charged the full session fee. Insurance companies do not reimburse for cancellations or no-show appointments and you will be responsible for full payment.

Crises: If the emergency is life threatening, call 911 or contact the Life Crisis Suicide Hotline at 314-647-4357. You may contact Diane at 314-550-6207 and attempts will be made to return your call within 24 hours.

Fees: The fee is \$125 per hour and will be collected at the end of each appointment. You may also be charged for lengthy phone calls.

Insurance: If insurance is used for payment of services, please be advised that insurance companies require a mental health diagnosis to determine medical necessity. In signing this consent form, you agree to allow your therapist to release information to the insurance company and billing service in order to process reimbursement.

Privacy: Adherence is made to all state laws and professional ethical standards regarding your privilege of confidentiality. If you want collaboration with a referral source, family member, or other service provider, you will be asked to give your permission in writing. In the unlikely event that there is a danger to someone's life or health, or if there is a suspicion of child abuse, appropriate authorities will be notified. Also, information about your therapy can be subpoenaed by a court of law. You are welcome to review your records with me at your request. If you wish to make copies for yourself or another professional, you will be asked to sign a release form. Your signature below indicates you have received this information.

Electronic Communication: Diane's phone messages and emails are password protected and only viewed/heard by her. Phone messages, texts and emails are used within Diane's practice primarily to conduct logistics of appointments or to convey resources, and not to discuss therapeutic matters. Diane does not participate in internet social networking sites with clients.

Signature: Your signature indicates that you understand and accept the above described policies. Your signature gives permission for treatment of any children listed on the first page. Your signature states that you have legal guardianship over the children listed and that you are allowed to seek counseling services for them. Please sign and date your signature.

Client _____ Date _____

Client _____ Date _____

Therapist _____ Date _____