Monica B. Levine LICSW
90 Conz Street, Suite #14
Northampton, Mass.01060

Name: _____ Today's Date:_____/_____/_____

Date of Birth:_____/_____/_____Social Security #_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Occupation:_____

Number of children (and ages):_____

Home Phone#:_____ Work Phone#:_____

Cell Phone#:_____ Email Address:_____

Please list any prescription medicines you are taking now including dose and purpose:

What issues bring you to therapy now?

What do you want most from the therapy experience?

Have you been in counseling before? What kind, and with whom?

Who referred you? _____
Address and phone #:_____

Who is your primary physician?_____
Address and phone #: _____

Please read and sign both statements:
I understand that I am responsible for all charges and I agree to make payment in full on the day of my visit unless another arrangement is specified by my insurance plan. I agree that appointments not cancelled 24 hours prior to appointment time are billed and to paid in full.
Signature:_____
I hereby give Monica Levine permission to contact the above- named referral source and primary physician or to respond if contacted by these specific individuals to discuss aspects of my personal health information. I have read and I understand the privacy policies which will be followed by Monica Levine to protect my personal health information.
Signature:
