

**Daniel T. Merlis, MSW, LCSW-C**

3825 Morrison St., NW  
Washington, DC 20015  
Phone 202-364-3637 x4  
Fax 202-364-3639

To New Clients:

I look forward to meeting with you very soon. I have asked you to complete this paperwork prior to our meeting so that we will not have to take time in our session to address these administrative details. Please complete the forms and mail or fax to me with payment for the initial consultation.

These are the forms which you will need to review/complete.

The ***Client Data Form*** provides me with basic identifying and contact information for yourself. Please make sure to enter contact information including fax number for any psychotherapist or psychiatrist you are currently seeing. Also, please complete the ***Release of Information Form*** included in your packet entering the name of the clinician (s) in the spaces provided. We will discuss the possibility of my having contact with that clinician as part of an initial evaluation. If you are a parent of a child who I will be seeing, please use your child's name as the client and complete the form accordingly.

The ***Client Clinician Agreement Form*** outlines my practice policies regarding financial matters, confidentiality of information, and other administrative issues. Please review this form completely. If you are not currently in psychiatric or psychotherapy treatment, please sign the form at the top of the second page. If you are currently in treatment and are seeing me for adjunctive treatment, please sign the form at the top and at the bottom of the second page.

The ***AudioVideo Consent Form*** must be completed by clients interested in a reduced fee schedule by participation in my Psychotherapy Training Project. This form must be separately downloaded from the Initial Consultation Section of the website and included with this intake forms package.

The ***Credit Card Authorization Form*** needs to be completed. You may elect one of two options. To charge all of your visits or to charge only those visits you do not pay for at the time of the visit by check or cash. I do not have a receptionist to handle these transactions with you at the time of your visits so this form will allow for automatic billing.

Thank you again for taking care of these administrative tasks prior to our initial meeting. We will be able now to focus all of our time on the personal concerns you wish to consult me about.

Daniel T. Merlis, LCSW-C

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3825 Morrison St., NW; Washington, DC 20015; Tel. 202-364-3637 x4; Fax 202-364-3639

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Fax number: \_\_\_\_\_ e-mail: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

By whom you were referred: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer/ School: \_\_\_\_\_

Current Spouse/Partner's Name, Age & Occupation: \_\_\_\_\_  
\_\_\_\_\_

Children's Name(s), Age(s): \_\_\_\_\_  
\_\_\_\_\_

Name, address phone of person(s) to be contacted in an emergency: \_\_\_\_\_  
\_\_\_\_\_

**FOR MINORS:** Parents' Names, Work, Home, and Cell Phone Nos.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name, address, phone of treating psychiatrist/psychotherapist: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Office Use Only:**

<b>Diagnosis:</b>	<b>Opened:</b>
<b>Basic Fee:</b>	<b>Closed:</b>

## CLIENT-CLINICIAN AGREEMENT

***This document reflects the policies of the Clinician, Daniel T. Merlis, LICSW, LCSW-C, regarding fees, privacy of records and confidentiality of information, and other administrative issues related to the provision of professional services to the Client.***

**FEE:** The fee is \$ 210.00 for 55 minutes. Longer sessions are billed as follows: 70 min- \$265; 85 min- \$315; 115 min- \$420. The fee may be reassessed on at least two months prior notice. The initial appointment is 55 minutes for individuals and 70 minutes for couples or families unless other arrangements are made in advance. The Reduced Fee Schedule for clients participating in the Psychotherapy Training Project is: 55 min- \$160; 70 min- \$200.

**MISSED APPOINTMENTS:** The Client agrees that if s/he is unable to keep an appointment, s/he will provide a minimum of 48 hours prior notice to the Clinician by leaving a message on the Clinician's voice mail or by speaking to the Clinician directly. Email is not adequate notice. **If an appointment is cancelled or missed without 48 hours' notice, the Client understands that s/he will be billed for the session.** In this event, the bill will reflect a late cancellation and not a clinical session. If the Clinician fails to provide 48 hours notice of cancellation, the next appointment shall be at no charge.

**PAYMENT METHOD:** Payment is required in advance for the initial consultation. Subsequent appointments are to be paid for at the time services are rendered or by other arrangements determined on an individual basis. Payments may be made by check, cash, or credit card. Should the Client elect to use credit card for payments, the Client agrees that the initial credit card authorization form may be used on a recurring basis for all scheduled treatment sessions including missed appointments. Payment by check at the time of the appointment will be accepted, otherwise the fee shall be charged to the Client's credit card. If, for whatever reason, the Client's account remains unpaid after 30 days, the Clinician reserves the right to suspend or discontinue treatment until the charges are paid in full or a suitable payment arrangement is agreed to in writing by both the Client and the Clinician. If payment is not made in accordance with this arrangement, there will be a brief time period devoted to terminating treatment during which the Clinician will offer referral assistance to the Client. If legal means are required to secure payment, the Clinician's reasonable legal costs will be charged and payable by the Client.

**INSURANCE AND THIRD PARTY PAYMENTS:** The Clinician does not accept direct insurance assignments. A monthly statement will be provided to the Client that can be submitted to the insurance company for reimbursement. At the Client's request, the Clinician will provide relevant clinical information to the insurance company for reimbursement purposes. The Client should be aware that most insurance companies require a clinical diagnosis, and some require additional clinical information that becomes part of their record. The Clinician assumes no responsibility for the continuing confidentiality of the information once it is released to the insurance company.

**BILLING FOR TELEPHONE CONTACTS:** Brief phone contacts with the Client of less than five minutes duration and calls relating to scheduling issues will not be billed; however, the standard fee will be charged on a prorated basis for telephone contacts with the Client of more than five minutes' duration. Except in situations where the Clinician assesses the Client to be at risk of self-harm or harm to others, phone or written contacts with family or friends will not be made by the Clinician unless approved by the Client in advance with a signed release of information.

**INTAKE PROCESS; CLINICAL CONSULTATION:** During the intake process, the Clinician will explore with the Client the nature of the Client's concerns and will determine whether the Clinician can treat the problem as presented, or whether a referral to another Clinician would be more appropriate. The fee will be charged for the consultative services provided by the Clinician during the intake process. The Client understands that until a plan of treatment has been developed and agreed upon by both Clinician and Client, all services provided are consultative in nature and the Clinician shall assume no obligation to provide continuing services to the Client. In the event the Clinician recommends services elsewhere, the Client will be offered referral assistance. The initial clinical consultation will be billed as an *Assessment (CPT Code 90801)* while subsequent consultation sessions will be billed as *Individual Psychotherapy (CPT Codes 90806 or 90808)*. A provisional diagnosis will be given on the bill for purposes of Client reimbursement from the insurance carrier. This diagnosis is subject to change based on further assessment.

**CONFIDENTIALITY:** All communications between Client and Clinician are confidential. Information will only be released to a third party under the following conditions: a) the Client authorizes the Clinician to release information with the Client's written permission; b) the Client is threatening serious bodily harm to self or another; c) the Clinician learns that a child, an elderly person or a disabled person has been or is being abused; d) pursuant to a court order in a judicial proceeding; e) or as requested in a professional board investigation. The Client understands and agrees that the Clinician's working notes are not considered part of the clinical record and will not be released to the Client or to any other persons, agencies or organizations under any circumstances. The Client understands and agrees that any records obtained from other clinicians, agencies, or institutions also will not be released by the Clinician under any circumstances. The clinical record shall include dates of contact, diagnosis, any evaluation forms completed by the Client and any treatment plan forms

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prepared for review by the Client's health insurance carrier. In clinical situations where more than one person is the 'Client', such as in couples or family consultation, evaluation, therapy or counseling, no information will be released without the written consent of **all** adults who participate. The Clinician will respond to any court order for records by providing only the dates of contacts and a general summary of psychotherapy/counseling activity. The Clinician will have broad discretion to release any information he deems relevant in situations (b) and (c) above where he believes the Client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

**TERMINATION OF TREATMENT:** The Client may terminate treatment at any time without moral, legal or financial obligation beyond payment for services already rendered. It is expected that the Clinician and the Client will discuss the prospect of termination so that both parties will be clear about any details that might need attention as part of the termination process. If the Client fails to schedule a future appointment, cancels a scheduled appointment, or fails to keep a scheduled appointment, and does not contact the Clinician within 30 days of the date of last recorded contact, it will be understood that the Client has terminated treatment. The Clinician shall have no further obligation to the Client once treatment has been terminated. Should the Client make contact with the Clinician at a later date requesting additional services, the Clinician may choose to see the Client on a consultative basis, or may recommend that the Client seek services elsewhere. The Clinician also may terminate the treatment if he determines the therapy process to be unproductive and/or if he determines that the Client would be better served by other health or mental health practitioners. Clinician will provide 30 days notice of intent to terminate to allow the Client to make other treatment arrangements.

The Client(s), by signing below, indicates that s/he fully understands and agrees to the policies stated on page 1 and page 2 above.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Daniel T. Merlis, LICSW, LCSW-C

\_\_\_\_\_  
Date

***AGREEMENT FOR ADJUNCTIVE TREATMENT ONLY***

**ADJUNCTIVE TREATMENT:** There are occasions where the Clinician might agree to provide adjunctive services to a Client who is in primary treatment with another provider. In these cases, it is understood that the adjunctive treatment will be focused and time-limited, usually limited to 10 sessions, in support of the primary treatment provided elsewhere. Because of potential problems in effectively coordinating treatment, it is understood that the Clinician, as an adjunctive therapist, may at any time make a clinical decision to terminate adjunctive treatment and will notify the Client and primary therapist of this decision. It is understood that upon termination of adjunctive treatment by either Client or Clinician, the Clinician will have no further clinical obligation to the Client.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Daniel T. Merlis, LICSW, LCSW-C

\_\_\_\_\_  
Date

**Credit Card Authorization:**

Please complete this form even if you will not be charging your sessions on a regular basis. Missed appointments and returned checks will automatically be charged to this credit account.

Client Name \_\_\_\_\_

**Name as it  
appears on credit card:** \_\_\_\_\_

Your Billing Address \_\_\_\_\_

\_\_\_\_\_

Credit Card Type:       Visa       MasterCard       American Express  
\_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

***Please Check One of the Two Options:***

\_\_\_\_\_ I authorize Daniel Merlis to process my credit card for payment of services on a recurring basis for all scheduled appointments including missed appointments, late cancellations, and returned checks.

\_\_\_\_\_ I authorize Daniel Merlis to process my credit card for payment of returned checks, missed appointments, late cancellations and visits for which I do not pay by cash or check.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## RELEASE OF INFORMATION

I authorize my psychotherapist, Mr. Daniel Merlis, to make contact, by phone, in writing, or in person with \_\_\_\_\_ and to release any and all information concerning me as may be necessary and/or helpful in my clinical evaluation, treatment planning, and treatment activity.

I authorize \_\_\_\_\_ to release any and all information requested by Mr. Merlis. It is my intention that the professionals with whom I have been in treatment and with whom I am currently in treatment be able to freely exchange information in order to best serve me.

\_\_\_\_\_  
Client's Name (Print)

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date