SUSAN ZOLA, LCSW, CCPS
LICENSED CLINICAL SOCIAL WORKER LIC.#078530
APSATS Assoc. of Partners of Sex Addicts Trauma Specialist
35 CROOKED HILL RD. STE 203 COMMACK, NY 11725
www.susanzola.com Phone - 631-332-2213 Email – suezola@me.com

BASIC INFORMATION (please print clearly)

Today's Date _____

Name_____

Address_____

_____

Cell Phone #_____

Home Phone #_____

Email_____Age_____Date of Birth _____

Employment_____Work Phone # _____

Preferred Days/Times for Appointments _____

_____

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Marital Status (Circle One)

Single ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widow/er** ☐

Number of Years _____Spouse's Name _____

Children's Name(s)/Age(s)/Lives with you? _____
_____

_____

Parent's Name(s)/Age(s) - Married/Divorced - Living/Deceased (Date & Cause)

_____

_____

Referral Name and Phone # _____

EMERGENCY CONTACT
Please name someone who may be contacted in case of emergency:

Name _____Relationship _____

Daytime Phone #_____Evening Phone # _____

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REQUEST / RELEASE FORM

Psychiatrist's Name and Phone Number _____

Physician's Name and Phone Number _____

Therapist's Name and Phone Number _____

I authorize Susan Zola, LCSW, CCPS to **request** all necessary clinical information from my Psychiatrist, Therapist, or M.D. with respect to any treatment I received.

Patient's Signature _____

I authorize Susan Zola, LCSW, CCPS to **release** all necessary clinical information requested to my Psychiatrist, Therapist, or M.D. with respect to any treatment I received.

Patient's Signature _____

MEDICATION INFORMATION

Medication/Dosage _____

Used For_____ Date Last Prescribed _____

Medication/Dosage _____

Used For_____ Date Last Prescribed _____

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WORKING RELATIONSHIP AGREEMENT

Appointment and Cancellation Policies

APPOINTMENTS

Appointments are typically scheduled on a weekly basis.
Every effort will be made to schedule your appointments at a time and frequency that is best for you.

The time we select together is reserved for you each week.

To schedule appointments, please call (631) 332-2213.

CANCELLATIONS

There is no charge for appointments cancelled or rescheduled at least 24 hours in advance. With shorter notice, you are agreeing to pay for the time you reserved, and you will be charged for a full session.
Your cooperation in keeping appointments is vital to your success.

In the event you are unable to keep your appointment due to an emergency or sudden illness, please contact me or have someone else contact me as soon as possible.
I will be concerned about you and will want to know your circumstances.

If you are going to be late for your session, please call and let me know so that I know you are safe. After 15 minutes past your session start time, if I have not heard from you, I will assume you are not attending and I cannot guarantee that I will still be here when you arrive.

FEES

Please have payment ready at the beginning of each session so that we do not lose any of our therapeutic time together.

The fee that we agree upon will remain in effect for 1 year from your initial consult.
After that, you may be asked for a moderate increase in your fee.

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PHONE CALLS, EMAIL & TEXT
Phone calls in between sessions will be billed at a pro-rated session fee. This does not include calls for scheduling purposes. There is no charge for calls lasting less than 5 minutes.

You may email (suezola@me.com) or text at any time for no charge. My responses will be brief but I am interested to hear any thoughts you might want to share in between sessions.

Please note, I do not return calls from Caller ID. If you would like me to return your call, you need to leave me a message. I frequently communicate with clients via text message, however, please keep in mind confidentiality cannot be guaranteed via text.

INSURANCE
I do not file any paperwork or speak directly to any insurance companies. I can provide you with a monthly statement that includes all of the information you may need to file with your insurance company for reimbursement for out of network providers. Given that all insurance plans vary, please contact your insurance company directly to obtain their policies regarding coverage for your sessions.

EMERGENCIES
I check voicemail regularly and typically return phone calls within 24 hours on Monday through Thursdays, and by the end of the day Monday for messages left Friday through Sunday. If you are experiencing a clinical emergency and are unable to reach me, please contact your nearest emergency room or call 911.
This is especially important if you are feeling suicidal or believe your safety is at risk.

CONFIDENTIALITY
Everything you discuss with me is confidential. However, there are some exceptions to confidentiality as dictated by law, which are detailed in the Limits on Client Confidentiality page.

If you are 18 years of age or older, regardless of whom is paying for your therapy, I need a signed release to speak to anyone (including parents) about your treatment.

If you have any concerns about these policies, please let me know so that we can discuss it during our initial session or at any time throughout the course of your treatment.

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OUR AGREEMENT

The therapy process exists to serve you in a manner that is safe, comfortable and appropriate. I am working in your interest, and my role is to help you identify and reach your goals.
I encourage you to discuss with me any feelings, concerns, thoughts and/or frustrations regarding our work together.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, AND AS THE PARTY RESPONSIBLE FOR PAYMENT, AGREE TO THESE CONDITIONS.

_____ _____

Client Signature Date

_____

Parental Signature if Client is Under 18

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LIMITS ON CLIENT CONFIDENTIALITY

I might be required by law to disclose confidential information about you if any of the following conditions exist:

- You are a danger to yourself or others.
- You are a minor and I reasonably suspect that you are the victim of abuse or neglect.
- You are a person over the age of 65 and I reasonably suspect that you are a victim of abuse or neglect.
- You are under the age of 16 and a victim of a crime.
- You are involved in a lawsuit and my records are subpoenaed.
- You have filed a lawsuit against anyone and have claimed mental or emotional damages as part of the suit.
- You have filed for reimbursement with your insurance company for your therapy sessions and they request your records.

In addition, you may give me written permission to discuss specific aspects of your case with other individuals with whom you deem necessary. These individuals may include psychiatrists, family doctors, past therapists, or family members.
If such a time occurs, we will complete and sign an Authorization for the Release or Exchange of Confidential Information form.

I have read and understand the above information, and I am consenting to treatment.

Client Signature_____ Date_____

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ADDITIONAL INFORMATION (OPTIONAL)

FAMILY OF ORIGIN

☐ **Natural** ☐ **Adoptive**

RELATION	Name	Age	Living or deceased (If deceased date and cause of death)	Current Relationship, i.e. Hostile/Estranged/Close/ Distant	Occupation and Place of Business/ Student/Other
Mother					
Father					
Sibling 1					
Sibling 2					
Sibling 3					
Sibling 4					
Sibling 5					

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CURRENT LIVING SITUATION

☐ Check here if the information is the same as family of origin.
(List only additional people in the home below

RELATION	Name	Age	Relationship (Grandparent, extended family member, friend or other)	Occupation and Place of Business/Student/ Other
1				
2				
3				
4				
5				
6				

PLEASE INCLUDE ANY ADDITIONAL INFORMATION YOU WOULD LIKE ME TO KNOW ABOUT

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Teletherapy Informed Consent Form

I _____ (client) hereby consent to engage in teletherapy with ___Susan Zola _____ (Clinician). I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In New York mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.

3. You understand that this teletherapy occurs in the state of New York, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the clinician in his/her New York office.

4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if the clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improve, and in some cases may even get worse

6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

Continued

7. I accept that teletherapy does not provide emergency services. During our first session, the clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

8. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.

9. I understand that while email may be used to communicate with the clinician, confidentiality of emails cannot be guaranteed.

Client Print Date

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