Joseph S.Weiss, PhD
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Cognitive Dynamic Therapy of Seattle - Office: (206) 402-4933

NAME: _____ DOB: _____/_____/_____ AGE: ____ SS# _____ _/_____/_____

SEX: __M __F MARITAL STATUS: ___SINGLE ___MARRIED ___WIDOWED ___DIVORCED/SEPARATED

ADDRESS_____
STREET APT# CITY STATE ZIP

HOME PHONE: (____) _____ - _____ WORK PHONE: (____) _____ - _____ CELL: (____) _____ - _____

E-MAIL ADDRESS: _____

EMPLOYER NAME AND ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: (____) _____ - _____

RELATIONSHIP TO PATIENT: ___SPOUSE ___PARENT ___GRANDPARENT ___OTHER: _____

RESPONSIBLE PARTY: _____ RP PHONE: (____) _____ - _____

RELATIONSHIP TO PATIENT: _____ RP SS# _____ /_____/_____ RP DOB: ____/____/_____

RP ADDRESS_____

RP EMPLOYER: _____ RP WORK PHONE: (____) _____ - _____

--PLEASE COMPLETE ALL QUESTIONS--

	YES	**NO**
Briefly state the **problems** for which you are seeking care:		
Are you currently under another professional's care for psychotherapy?	☐	☐
Have you had psychotherapy in the past?	☐	☐

If yes, when and with whom? _____

--- PLEASE TURN OVER ---

Referral sources appreciate acknowledgment.

Do we have permission to thank referral? YES ☐ NO ☐

Referral Source: _____

Address (if available): _____

Or phone: _____

CANCELLATION POLICY – 24 HOUR NOTICE

Since it is typically not possible to fill a session cancelled less than 24 hours in advance, a missed session or late cancellation will be charged to you though it was not attended. Please note that insurance companies do *not* pay for missed sessions and **you will be responsible for the full amount.**
If you have any questions, please contact our business office. ___ Initial

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ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I authorize payment of medical benefits to Cognitive Dynamic Therapy of Seattle and Joseph S. Weiss, PhD. or any of its representatives on my behalf for services furnished to me by any member of their group practice. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by an insurance carrier. By signing below, I hereby authorize said assignee to release any information necessary to secure payment.

CONSENT FOR TREATMENT

I consent to psychological evaluation and treatment by Dr. Joseph S. Weiss of Cognitive Dynamic Therapy of Seattle. I understand and accept the CDTS policies. I understand that I may discuss my treatment with my therapist and may withdraw my consent if I so desire. I further understand that no guarantees have been made to me about the outcome of this care.

My signature indicates that I have reviewed and truthfully responded to the information requested on this form. I have read and understand the above cancellation policy, assignment of benefits and consent for treatment. I agree to adhere to them until further written notice.

Client Signature: _____ **Date:** _____/_____/_____

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

--NOTE: YOUR SIGNATURE REQUIRED--

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