WEINSTEIN WELLNESS
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Welcome Form

Welcome to your first session at Weinstein Wellness! Please review it carefully and feel free to ask any questions.

About my Services
The potential benefits of therapy are many and may include improved personal & professional functioning, relationships, self-image, and mood. However, in some cases, people report feeling worse after therapy. Clients understand that healing, growth, & change can be difficult and that some discomfort may be a part of the therapeutic process. We will address and move through any difficult &/or painful memories, emotional states, & thought patterns that may emerge. If you are interested in learning more about yoga & incorporating any physical &/or mental benefits of such practice, clients will not hold me (Erica Weinstein, LCPC), nor my practice (Weinstein Wellness), accountable in any way for possible injury.

Scheduling & Cancellations
Scheduling an appointment is a commitment that both the therapist & client honor. Appointments can be cancelled or rescheduled with at least 24 hours notice. If sessions are cancelled or rescheduled with less than the required notice, or if a client misses a session, the client agrees to pay for the missed appointment. Please know that exceptions to this policy may be made in the event of a serious medical or family emergency.

Work Agreement
It is agreed that the client shall engage in the therapeutic process as a priority in her/his life. Suspension, termination, or referral shall be discussed between therapist & client for a pattern of behavior displaying disinterest, lack of commitment, or for any unresolved conflict or impasse between therapist & client.

Emergency Contacts
The client will provide at least two emergency contacts. These emergency contacts may be used if I am unable to reach you & I perceive a need. If you are in crisis and cannot reach me, please contact emergency services (911) or go to your nearest emergency room.

Service Fees
Sessions are $150 and are subject to change.

We, the therapist & client, have read and fully understand and agree to honor this agreement. We have also agreed to an initial definition of work and to the fee to be paid by the client.

Client Name (s) _____ Date: _____
Provider Name _____ Date: _____

Client First Name _____ Last Name _____

Address _____

Birthdate _____ Age _____

Phone Number _____ Email Address _____

Reason(s) for Seeking Therapy/Guidance/Counseling _____

_____

_____

_____

_____

Intake Date _____

Person Responsible for Payment _____

Signature of Person Responsible for Payment _____

(must be signed for services to begin)

Full Name of Spouse/Guardian _____

Address _____

Phone Number _____ Email Address _____

Emergency Contacts

Full Name _____ Relationship _____

Address _____

Phone Number _____ Email Address _____

Full Name _____ Relationship _____

Address _____

Phone Number _____ Email Address _____

Physician/NP _____ Phone Number _____

Address _____

Psychiatrist/PNP _____ Phone Number _____

Address _____

Current Medications _____