Foojan Zeine, Psy.D., MFT

Date: _____

Client Name _____ Birthday __ /__ /__

Spouse Name _____ Birthday __/__/__

If Client is a Minor; Parents' Name _____

Signature for authorization of treatment _____

Address _____

City_____ State _____,Zip_____

Phone: H _____ Cell _____ Email _____

In case of emergency contact _____Relation _____Tel_____

Credit Card # _____Exp. Date_____ Code _____

All information will be treated as **confidential** except: a) report of child or elder abuse, b) report of intent to harm self or other, c) legal subpoena only if issued by a judge directly requiring waiver of the privilege of confidentiality d) professional supervision) collection of fees.

Sessions are fifty minutes, at scheduled time. **Rescheduling must be done 24 hours in advance, or you will be charged for the missed session.** The agreed upon **FEE** is **$150.00** for telephone/on-line sessions and **$200.00** for in office**.** Payments can be made with a credit card. Payment in full is expected at end of each session.

For third party payment, I authorize the release of information and the payment directly to Foojan Zeine. I agree that I am fully responsible for the payment of my treatment. I authorize Dr. Foojan Zeine to charge the credit card number stated above for the agreed upon fee stated.

If immediate attention is needed please call Foojan Zeine at **818-648-2140**. In case of emergency please call 911.

Thank you for reading this carefully. If there are questions about these policies, please voice them at the beginning of any session so that our therapeutic relationship can support the changes you want to make in your life.

I have read and understood these policies and give authorization for treatment.

_____ Date_____

Signature (Parent's signature if minor)