Deborah L. Klinger, M.A., LMFT, PC
Deborah Klinger, M.A., LMFT, CEDS-S
1415 Broad St.
Durham, NC 27705
919-990-1143 www.deborahklinger.com

Date _____

Name _____ Date of Birth _____ Age ____

Address _____City _____Zip_____

Phone#: Main _____ Work _____ Other _____

Email address(s) _____

Employer/School _____

Occupation _____ Part time _____ Full time _____

Single _____ Married ____ Living w/partner ____ Divorced/separated _____ Other ____

How/where did you hear about me?
_____

Are you currently taking any medication? Y/N If yes, please specify the medication(s) and the reason you are taking it/them:
_____
_____
_____

Name and contact information of the doctor who prescribes your medication:

_____

_____

_____I give Deborah Klinger, M.A., LMFT permission to contact this person for the purposes of coordination of my care.

Medical conditions:
_____
_____
_____

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Name and contact information of the doctor who treats you for these conditions:

_____

_____I give Deborah Klinger, M.A., LMFT permission to contact this person for the purposes of coordination of my care.

Have you seen a therapist before Y / N ?

If yes, please give the name of the therapist, a brief description of the problem and degree of resolution:

_____
_____
_____
_____

What brings you in to therapy at this time?

_____
_____
_____
_____
_____
_____

Is there anything else you feel would be helpful for me to know about you?

_____
_____

In case of emergency, contact (name/phone#/relationship to you):

_____

_____I give Deborah Klinger, M.A., LMFT permission to contact this person in case of emergency

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This document is a summary of my working arrangements with clients. It is intended to assist in clarifying questions that commonly arise in a therapeutic situation. Please let me know if you have any questions about an of these items. We'll discuss them in your initial session.

- **Length of Sessions**: The initial session is 60 minutes long. Subsequent sessions are 45 minutes long for individuals and 50 for couples/families, unless otherwise specified. With respect to individuals, 55-60-minute sessions are an option, if we agree that this would be more appropriate, either occasionally or on a regular basis. Frequency of sessions is mutually determined.

- **Cancellations**: excepting emergencies, sessions must be cancelled **24 hours in advance**, or the full fee for the session will be charged. If a portion of your fee is covered by insurance, you are responsible for the **full fee** in the event of a cancellation without 24 hours' notice. I cannot bill insurance for a missed session. If you need to reach me within 24 hours of a scheduled session for any reason, call or text my cell, **919-452-5943.**

- **Confidentiality:** The normal confidential relationship between client and therapist does not cover disclosures of child or elder abuse or neglect, or intent to harm another or oneself. You may give me written permission to speak to significant others and/or other professionals involved in your care. I may consult with other professionals about you without your explicit permission so long as I do not give details that would reveal your identity. I may contact your designated emergency contact person in case of emergency, including situations in which I am unable to reach you and have justifiable concerns about your wellbeing.

- **Phone calls**: The telephone number above is voice mail only. I check my voice mail regularly and will return any messages as soon as possible. If you want to reach me immediately, my cell phone # is **(919) 452-5943**. You are welcome to call or text me on my cell. For texting, please download the free, secure app, Signal. This will ensure that our conversations are encrypted. Please keep confidentiality issues in mind if you choose to use texting, especially if you choose to use regular SMS or iMessage instead of Signal. Any telephone or text conversations, or time listening and responding to voice mail messages exceeding 7 minutes will be considered a full session and charged as such. This also applies to communications between me and anyone you've given me written consent to speak with.

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- **Email:** I cannot guarantee that email correspondence will be confidential. My Hushmail account, **dklinger@deborahklinger.com**, is encrypted in cyberspace, in accordance with privacy requirements, but not in your computer or mine, unless you elect to have an added an extra layer of encryption, which means you would need to create a password in order to unlock and read emails. Please let me know whether you accept or decline that option. Any email correspondence requiring more than 7 minutes of my time will be charged as a session. This also applies to communications between me and anyone you've given me written consent to speak with.

- **Insurance**: If you are using insurance other than the Duke University student plan, I can give you a statement to file claims using out-of-network benefits, or I can file for you. I charge $5 per month to defray the costs of the billing service I use to file claims. If I am filing claims for you and have done so accurately and appropriately, and for any reason your insurance plan fails to pay me for my services, you are responsible for payment.

I understand and acknowledge the above:

Printed name: _____

Signature: _____ Date: _____