Mary weber-Young Ph.D. LPC, LCSW

Today's Date_______________ Your Name______________________________
Date of Birth____
Home Address____
City, State______________________________________ZIP_______________________
Home Phone_____________________Work Phone______________________________
EMAIL_____________________
May I call you at home or work and tell my name to anyone who answers? Yes__ No__
In case of an emergency, notify____
Physician's Name____
Medication you are currently taking____
Have you previously been on any medication for a psychiatric condition? Yes___ No___
If yes when? ____
Have you been in therapy previously? Yes____ No____
If yes, where and when? ____
How were you referred to me? ____
May I use your name in a thank you to this referral source? Yes___ No___

Fees and Payment Information

Assessment (1st session)	**Individuals**	**$125.00**	**(45 minutes)**
	Couples/family	**$145.00**	**(60 minutes)**
Ongoing sessions:	**Individuals**	**$110.00**	**(45 minutes)**
	Couples/family	**$125.00**	**(60 minutes)**

Payment is due at the time of your appointment. M/C, Visa & Discover accepted.

Please Note: Because the agreed upon time will be reserved for you, payment is expected in full for appointments not canceled at least 24 hours in advance. Messages can be left at 314-378-6410 24 hours a day.

Telephone Consultation
Billed incrementally for time used based on session rate of $110.00 per forty-five minutes.
Insurance
You are responsible for paying the full fee at the time of your session, and for requesting your insurance claim to be paid directly to you. I will provide you with a HCFA form at the end of each month, which will detail all sessions for that month. This claim can be attached to your claim form for submission to your insurance carrier. This does not guarantee that services will be reimbursed and will vary according to the provisions of your insurance carrier. Insurance companies may not be billed for missed sessions. Please complete the following or provide a copy of your insurance card if you plan to submit a claim for mental health insurance coverage:
Insurance Company_________________ Group #________ ID#_________ Insured

Please initial the following:
____I understand and agree to the above. I agree to be responsible for full payment for professional services rendered.
____I have received a copy of the therapist-client agreement
____I have received a copy of HIPPA privacy notice
____Dr. Weber-Young may release information to my insurance company

Signature____