Marcia Newman, M.A., L.M.F.T.
Psychotherapy & Wellness Consulting
Tel 805-750-3759
Email: Marcia@MarciaNewman.com
www.MarciaNewman.com

Dear

We are scheduled for a Consultation on
I have allotted **45 Minutes for your Initial Consultation at the rate of $**
Follow up Consultations are 45 minutes for $ **Extended consultation times are available and are pro-rated.**
Full payment is required at the time of service via Cash, Credit Card or Check payable to: **Marcia Newman, MA, LMFT.** You will be provided a receipt for services provided. If you are unable to make your scheduled appointment, please **give 24 hours notice of cancellation to avoid a $ missed appointment fee.**

If you would like to utilize your mental health insurance a psychological diagnosis is required and will be deemed a psychotherapy session. To obtain possible reimbursement, you may send your receipt to your insurance company. If you choose the psychotherapy option, you will receive my *Notice of Privacy Practices* which provides information on how I may use and disclose your protected health information. By signing this form, you acknowledge that I have given you my *Notice of Privacy Practices*. **If you are a medical patient at the clinic of Dr's Hanzelik, Horton & Daya and would like to utilize your mental health insurance, please speak with Marcia before your scheduled session.**

If you choose to receive *Reconnective Healing®* Sessions and/or *The Reconnection®* it is agreed that you have read the information provided on my website or in my brochure. I have been authorized by Dr. Eric Pearl to perform *Reconnective Healing®* Sessions and *The Reconnection®*. By signing this form, you understand that *Reconnective Healing®* Sessions and *The Reconnection®* do not involve any diagnosis or medical treatment, and are not to be substituted for regular medical care. While some persons have experienced healing after receiving *Reconnective Healing®* Sessions and/or *The Reconnection®* you agree that there is no guarantee, either expressed or implied, of any particular outcome. By signing this form, you understand and accept that you are solely responsible for seeing to, and continuing with your own medical treatment/health care. *Reconnective Healing®* Sessions and *The Reconnection®* do not qualify for mental health insurance reimbursement at this time.

Name ____

Street Address ____

City ______________________________ State__________ Zip ____________________

Home Phone (_____)______________________ Cell Phone______________________________
OK to Text this number for appt-related matters? ____YES ____NO

Work Phone (_____)______________________

Birth Date ________________________ Age ______________

Email Address ____
(To be used for scheduling, appointment reminders & and to receive my free monthly E-newsletter)

I have read, understood and agreed to the above information and that it is my desire to receive consultation(s) with Marcia Newman.

____
Client Signature(s) Date

____
Marcia Newman, M.A., L.M.F.T. Date
TAX ID-EIN 27-4592496
California Licensed Marriage & Family Therapist–MFC #43065
Florida Licensed Marriage & Family Therapist–LMFT #1862
Wisconsin Licensed Marriage & Family Therapist –LMFT #421
Wisconsin Licensed Professional Counselor--LPC-#1851