**Elizabeth Simpson, LICSW**
**126 Prospect Street, Suite 7**
**Cambridge, MA 02139**
**Ph: 857-719-9962**
**Simpsoneliz1@gmail.com**

**Today's Date: _____ Date of 1st session: _____**

**Referred by: _____**

**PATIENT INFORMATION**

Name (legal): _____

Name (preferred): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Ok to leave message? _____ Ok to text? _____

Email: _____

Birthdate: _____ Age: _____

Sex, according to insurance policy: _____ Preferred pronouns: _____

*In the event of an emergency, please contact:*

*Name:* _____ *Phone:*_____ *Relationship:*_____

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**PATIENT or AUTHORIZED PERSON'S SIGNATURE REQUIREMENTS**

## *Treatment Agreement and HIPAA Notice*

**I (patient, parent or guardian) have read the Psychotherapy Professional Practices and Treatment Agreement, which contains the HIPAA notice, and agree to its terms.**

**Signed**_____**Date**_____
**(Patient/authorized person)**

## *Cancellation Policy*

**I (Elizabeth Simpson, LICSW) request that you give me at least 48 hours notice if you must cancel an appointment. If you must cancel on short notice for unavoidable reasons, please call to let me know that you are not coming. I charge your normal session fee for late cancellations or missed appointments if we are not able to reschedule your time within the two weeks following the missed appointment. Please be aware that insurance companies will not pay for canceled or missed appointments.**

**I have read and understand the cancellation policy.**

**Signed**_____ **Date**_____
**(Patient/authorized person)**

## *Release of Information (for Medicare patients)*

**I (patient, parent or guardian) authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.**

**Signed**_____**Date**_____
**(Patient/authorized person)**

## *Assignment of Benefits (for Medicare patients)*

**I (patient, parent or guardian) authorize payment of medical benefits to: Elizabeth Simpson, LICSW**

**Signed**_____ **Date**_____
**(Patient/authorized person)**