Judith M. Glasser, Ph.D.
Clinical Psychologist
10831 Lorain Ave.
Silver Spring, MD 20901
and
6218 Montrose Rd.
Rockville, MD 20852
301-681-3223

Client Information Sheet

Date of Initial Appointment _____
Name of Client_____ Date of birth_____
Name of Parent_____ SSN: _____
(If client is less than 18 years old)

	Permission to leave voicemail at this number:	
Home Phone: _____	__Yes	__No
Work Phone: _____	__Yes	__No
Cell Phone: _____	__Yes	__No

I, _____, give Judith M. Glasser Ph.D. permission to communicate with me via email at the following email address: _____ in order to set or change appointments, or in response to phone calls or emails from me.

Signature: _____
Address: _____
City, State, Zip: _____

Emergency Contact: _____ Cell Phone: _____
Relationship: _____ Work Phone: _____

Who referred you to Dr. Glasser? _____

Are you in treatment with a psychiatrist, psychologist, or psychotherapist? Yes No
If so, please provide the names: _____
Phone numbers: _____

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Client Informed Consent Statement

HIPPA: I have been given an explanation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Fees: I have been informed of and agree to the charges for services for Judith M. Glasser, Ph.D.

Online therapy: I understand that all current therapy will be online due to the pandemic. I use a HIPPA compliant platform, DoxyMe.

Insurance coverage: I understand that Judith Glasser PhD is not a Medicare provider and does not serve on any insurance panels. I understand that my health insurance plan may not provide out of network coverage for these fees and that it is my responsibility to inquire about insurance coverage and to submit insurance claims.

Billing statements: I understand that Judith Glasser submits invoices on a monthly basis. I understand that failure to pay the bill in full will result in legal action.

Cancellation Policy: I understand that I will be charged for cancellations made less than 24 hours in advance except in cases of emergency or inclement weather.

Confidentiality: I understand that Dr. Glasser may not communicate verbally or in writing with any other professional about my case without my written permission except in specific instances outlined in the policies and procedures document.

Records review: I understand that Dr. Glasser requests non-original copies of all client records given to me for review.

Records retention: I understand that in the case of adults, clinical records will not be kept longer than 5 years following the last session. In the case of minors, records will be kept for 5 years or until their 21st birthday, whichever is later.

Informed consent: I certify that it has been explained to me what treatment and/or testing may involve and that I understood what I was told. I also understand that I have the right to withdraw myself and/or my child from treatment at any time.

Printed legal name: _____

Signature: _____ **Date:** _____