

**Bethesda Psychological and Family Services, LLC**  
**Matthew S. Burgess Leary, Ph.D.**

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Bethesda, MD 20814

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**Client Registration Information**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_  
Age: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Country of Origin: \_\_\_\_\_

Current Address: \_\_\_\_\_ Phone: Home: \_\_\_\_\_  
Work: \_\_\_\_\_

Email address: \_\_\_\_\_ Cell: \_\_\_\_\_

Education: \_\_\_\_\_ Employment Status: \_\_\_\_\_

Occupation/Job title: \_\_\_\_\_ Number of Years: \_\_\_ yrs \_\_\_ mths

Place of Employment: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Psychiatrist: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

How were you referred to this office? Please check any that apply  
Refer by friend \_\_\_ Refer by professional \_\_\_ If so, whom? \_\_\_\_\_  
Google search \_\_\_ Website \_\_\_ Other search \_\_\_  
Psychology Today \_\_\_ Good Therapy \_\_\_ Zencare \_\_\_  
Therapy Den \_\_\_ Other (please specify) \_\_\_\_\_

Relationship Status: \_\_\_ Single \_\_\_ Engaged \_\_\_ Married/Civil Union \_\_\_ Separated  
\_\_\_ Living Together/Domestic Partners \_\_\_ Divorced \_\_\_ Widowed  
\_\_\_ Other (please specify): \_\_\_\_\_

How long have you been in your current relationship? \_\_\_\_\_  
How many children do you have from your current relationship? (Circle those living with you)  
Names and ages? \_\_\_\_\_

How many children do you have from previous relationships? (Circle those living with you)  
Names and ages? \_\_\_\_\_

Are there any relatives or other persons living in your home? \_\_\_\_\_  
If yes, please specify: \_\_\_\_\_

*Partner Information (if applicable)*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Current Address: \_\_\_\_\_ Phone: Home: \_\_\_\_\_  
(if different) \_\_\_\_\_ Work: \_\_\_\_\_  
\_\_\_\_\_ Cell: \_\_\_\_\_  
Education: \_\_\_\_\_ Employment Status: \_\_\_\_\_  
Occupation/Job title: \_\_\_\_\_ Number of Years: \_\_\_yrs \_\_\_mths  
Place of Employment: \_\_\_\_\_ Address: \_\_\_\_\_

**Informed Consent for Treatment**

I give my consent for the staff of Bethesda Psychological and Family Services to provide a mental health evaluation and appropriate treatment for myself and/or my child and family. I understand that I am a partner and collaborator in my treatment, and that my therapist will work with me to develop a process of treatment that will be helpful to me. I also understand that I can and am encouraged to ask questions, bring up concerns, and pay attention to and share my feelings about my therapist or the course of therapy at any time, and my therapist will address these questions, concerns, or feelings with me. I also understand that I can be informed and proactive in my treatment, and that I am always free to seek a second opinion.

I understand that psychotherapy, while ultimately oriented towards my growth, can bring up painful emotions about the past or present in my life, as well as highlight negative patterns I engage in, which can be uncomfortable and cause me distress. I am encouraged to share these feelings with my therapist. I understand that I can discontinue treatment at any time, but I agree to discuss termination of therapy with my therapist for at least one session prior to discontinuing.

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal guardian signature:** \_\_\_\_\_

**Consent for Treatment of Medical and Psychiatric Emergencies**

I give my consent for this office to initiate first aid measures, to contact my Primary Care Physician, or alert the emergency medical system. I also consent for my emergency contact to be notified.

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal guardian signature:** \_\_\_\_\_

### **Fees, Insurance, and Financial Agreement**

To preserve your autonomy and confidentiality regarding treatment decisions, Bethesda Psychological and Family Services (BPFS) does not participate in-network with any insurance companies. Since I am a licensed psychologist, my fees qualify for reimbursement under most insurance plans if you choose to use insurance. My fees are generally considered within the “usual and customary” (UCR) range. You may request a statement for your insurance if you would like to submit using your out-of-network benefits.

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Fees are due at the time of service unless we have previously established some other payment plan. BPFS accepts cash, personal checks, money orders, Visa, or Mastercard. Personal checks that are returned for insufficient funds are subject to a \$50 returned check fee.

If I choose to use a credit card, I authorize BPFS to hold this card on file and charge any outstanding balances to this account. I can revoke this authorization in writing at any time.

Credit card type: \_\_\_\_\_ Credit Card Number: \_\_\_\_\_  
Expiration date: \_\_\_\_\_ CVV: \_\_\_\_\_

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Missed Appointments**

For individual, couples, and family therapy, Bethesda Psychological and Family Services requests 48 hours notice to cancel an appointment to maximize the appointment availability for all other clients. Please be aware that failure to do so will result in a charge of the full session fee. I understand that, at the discretion of my therapist, this fee will be waived in the event of significant illness or family emergency, or in the event that I am able to reschedule my appointment for an alternate available time during the same week. I also understand that if I frequently cancel appointments (2 or more times per month), even with the 48 hour notice, my therapist and I will need to discuss this pattern and make additional payment arrangements if I would like to continue regular sessions.

For group therapy, I understand that I am responsible for the full fee for group each week whether or not I attend, and I will be charged monthly based on the number of times the group is scheduled to meet during that month.

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal guardian signature:** \_\_\_\_\_

## Personal Information

Please take a moment to help me better understand your situation. All of the information you share here will be kept strictly confidential as part of your protected health information. I look forward to working with you to address these and any other psychological concerns that you bring to therapy.

Reason(s) for today's visit: \_\_\_\_\_

Do you see yourself struggling with:

_____ Depression	_____ Anxiety
_____ Substance use	_____ Anger
_____ Relationship issues	_____ Life transitions
_____ Self/identity issues	_____ Grief / loss
_____ Struggles with traumatic experiences	
_____ Other: _____	

Any medical problems or issues: \_\_\_\_\_

Current Medications & Doses:

1. Medication & dose \_\_\_\_\_ For what? \_\_\_\_\_
2. Medication & dose \_\_\_\_\_ For what? \_\_\_\_\_
3. Medication & dose \_\_\_\_\_ For what? \_\_\_\_\_
4. Medication & dose \_\_\_\_\_ For what? \_\_\_\_\_
5. Medication & dose \_\_\_\_\_ For what? \_\_\_\_\_

Have you experienced therapy before? \_\_\_\_\_ Never  
\_\_\_\_\_ Yes: How many therapists: \_\_\_\_\_

What was helpful? \_\_\_\_\_

What was not helpful? \_\_\_\_\_

Have you ever been admitted to a hospital for psychiatric reasons:

\_\_\_\_\_ Never \_\_\_\_\_ Yes: How many times: \_\_\_\_\_ Date of most recent: \_\_\_\_\_

What are your main goals for therapy? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_