Christian Counseling Center
of the
Finger Lakes

Herb Masser, C.S.W.-R

Date.....

Name..... Phone (H)..... (W)..... (Cell).....

Address..... E-Mail address.....

..... State.....Zip..... SS#.....

Date of Birth.....Age.....Employed by.....

Spouse's Name.....Age.....Date of Birth.....SS#.....

Doctor's Name..... Insurance Co.....

Current Medications.....

Reason for counseling. (Why are you here?).....

What have you done about this? .....

What would you like to accomplish in counseling? .....

How did you hear about this office? .....

Information pertaining to an individual's counseling will not be released or transferred to a third party without his/her written permission.

Exceptions are:

1.) When an individual's thoughts or actions pose an immediate threat to themselves.
2.) When an individual's thoughts or action pose an immediate threat to others.
3.) When the counselor has reasonable cause to believe that child abuse or neglect has occurred.

Where possible insurance will be billed for counseling sessions. Co-payment is due at the time of service. A twenty-four hour notice is necessary for canceling an appointment.

Signed.....

Signed.....