Ruth Cohen Kubicek, LCSW, CADC, RYT **Counseling Clinic, Ltd.**
The Park at Plum Creek
871 S Arbor Vitae, Ste 003
Edwardsville, IL 62025

Telephone: (618) 659-9111
Fax: (618) 692-9111

PATIENT APPLICATION

Name: _____ Birthdate: _____ Age: _____

Address: _____City: _____ State: _____ Zip: _____

Telephone: (Home)_____(Work)_____(Cell):_____

Emergency Contact: _____ Phone #: _____

Social Security Number: _____E-Mail: _____

Occupation:_____Employer:_____

Highest Level Education Achieved: _____Religion:_____

Marital Status: _____ Spouse/Partner's Name: _____

Children's Name(s) and age(s):_____

Spouse/Partner's Employer: _____

Current Medical Problems: _____

Current Medications: _____

Physicians Name(s):_____

Names of previous therapists: _____

Who referred you to the Counseling Clinic? _____

Expectations of therapy? _____

Fees: Individual therapy - $150.00, Group therapy - $45.00.

Payment is expected at the end of each session, unless previous arrangements have been made.
PLEASE NOTE: IF A SESSION NEEDS TO BE CANCELLED, PLEASE PROVIDE AT LEAST 24 HOURS NOTICE OR A $60.00 FEE WILL BE CHARGED FOR THE TIME RESERVED.
PLEASE READ "CONSENT TO TREATMENT" AND "RIGHTS AND RESPONSIBILITES" on the reverse of this application and sign. Your signature is an acceptance of this application, consent to treatment and rights and responsibilities of this clinic.