TAMPA BAY CENTER TBCforCBT COGNITIVE BEHAVIOR THERAPY

For staff use:
Provisional Dx: _____
Rates: Therapy _____ Grp _____
Therapist: _____

CLIENT REGISTRATION *(please print)*

Client's full name: _____ Sex: _____ Age: _____

Today's Date:___/___/____ Date of Birth: ___/___/___ SS# _____

Home Address: _____

Phone: (w) _____ (c) _____ (h) _____

Email: _____

Client Employer/School: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Full Name: _____ Relationship _____

Home Address: _____

Phone: (w) _____ (c) _____ (h) _____

Will you be submitting for out of network benefits? Yes_____ No_____ Your statements and billing information will be available on the "Patient Portal" of our electronic Medical Record, Valant.

Insurance Company _____ Member #_____ Group #_____

Subscriber Name _____ Client relationship to subscriber _____

I would like to be put on the TBCforCBT mailing list Yes_____No _____

The rates for therapy vary from $20.00 to $180.00 depending on the level of experience of the therapist. Requests for scholarship rates will be considered at the consultation session. Group rates are paid monthly at $60.00 a session for adults and & $70.00 a session for the teen group. There may be a separate charge for excessive paperwork or other collateral contacts if needed beyond the allotted session time. Additionally I understand that my insurance may not reimburse me and that TBCforCBT will not bill the insurance company, but will provide an invoice to submit for reimbursement if requested. I understand that I am responsible for the full amount of my bill for services provided and there is a $75.00 cancellation fee if the session is not cancelled within 24 hours of the scheduled time. There is no reimbursement for missed groups.

_____ _____
Signature Date

_____ _____
Responsible Party Signature Date