



CLIENT REGISTRATION (please print and bring to the session) Today's Date: _____

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

Date of Birth: _____ Preferred Phone: _____

Email: _____

Home Address: (street, city, state & zip) _____

Referred By: _____

Emergency Contact: _____ Phone: _____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Full Name: _____ Relationship: _____

Home Address: _____

Preferred phone: _____ (circle) work/cell/home

Place of Employment: _____

Are you interested in being on the TBC for CBT mailing list for newsletters? Yes _____ No _____

Will you be filing claims for out of network benefits? Yes _____ No _____

Your billing information will be sent to you monthly on the "Patient Portal" of our electronic Medical Record, Valant. The rates for therapy vary from \$20.00 to \$200.00 depending on the level of experience of the therapist. Requests for scholarship rates will be considered at the consultation session. Group fees are paid per module regardless of attendance at \$60.00 -\$80.00 a session We collect a credit card authorization form to keep on file for your convenience. There may be a separate charge for excessive paperwork or other collateral contacts if needed beyond the session time. Additionally, I understand that my insurance may not reimburse me, and that TBC for CBT will not bill the insurance company but will provide a "superbill" to submit for claims. I understand that I am responsible for the amount of my bill for services provided and there is a cancellation fee of up to the full session fee if the therapy session is not canceled within 24 hours of the scheduled time. Signing this form indicates that I have been provided policies re: HIPAA, the Good Faith Estimate and the Informed Consent to Treatment and agree. .

Client Signature Date

Responsible Party Signature Date TBC staff initials