TAMPA BAY CENTER
TBCCBT
COGNITIVE BEHAVIOR THERAPY

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 $30.00 to $225.00 depending on the level of experience of the therapist. Requests for scholarship rates will be considered at the consultation session. Additionally, I understand that my insurance may not reimburse me, and that TBC for CBT will not bill the insurance company bill but will provide a "superbill" to submit for claims. I understand that I will be held financially responsible for any individual or group therapy sessions I miss with my provider, regardless of given notice. This means that I can still be charged up to my regular rate for individual/group therapy if I miss a given session. I understand that for group therapy, clients commit to attend the group on a per-module basis, meaning I can be charged for each session in each module (6 sessions total; $60-80 per group) that I commit to, regardless of attendance. Any disputes about these charges are to be discussed with my provider. Signing this form indicates that I have been provided policies re: HIPAA, the Good Faith Estimate and the Informed Consent to Treatment and agree to the above statements.

_____ _____
Client Signature Date

_____ _____ _____
Responsible Party Signature Date TBC Staff Initials

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