



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 ___

By signing this form, I understand the following: Billing statements will be sent monthly through the patient portal, Valant MYIO. The rates for therapy vary from \$50.00 to \$250.00 depending on the assigned therapist's level of experience, which is subject to change (with notice) with the increasing experience of the therapist. Requests for scholarship rates will be considered at the consultation session. My insurance may not reimburse me, and TBC for CBT will not bill the insurance company but provide clients with a "superbill" to submit for claims. If I do not provide 24-hr's notice to cancel/reschedule an individual therapy session, I can be held financially responsible for said missed session, meaning I can be charged up to my regular rate for therapy if I miss a given session. For group therapy, clients commit to attend the group on a per-module basis, and I will be charged my regular fee for group therapy for each group session within each module that I commit to, regardless of attendance. If I am the caregiver of a minor client, I will be responsible for payment of my child's therapy fees, including late-cancel and no-show fees, even when my child schedules their own sessions. If late cancellations and no-shows become a pattern, the counselor will encourage a joint discussion between me, my child, and the counselor to discuss possible solutions. Any disputes about these charges are to be discussed with the assigned therapist. 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 aforementioned statements.

Client Signature

Date

Responsible Party Signature

Date

TBC Staff Initials