Westercamp Counseling, LLC
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CLIENT REGISTRATION

DATE:_____

CLIENT NAME: _____

CLIENT PREFERRED NAME:* _____ (*all mail and non-legal documents will use this name unless you request otherwise)

RESPONSIBLE PARTY: (if client's under the age of 18)_____

HOME ADDRESS:

_____

_____

TEL (HOME): _____TEL (WORK):_____

TEL (CELL): _____ EMAIL: _____

CLIENT DATE OF BIRTH: _____AGE: _____

SINGLE _____ MARRIED _____

GENDER: ___Woman ____Man ____Transgender ____Other: _____

OCCUPATION: _____ EMPLOYER: _____

CONTACT IN CASE OF EMERGENCY: _____

RELATION(S) to CLIENT: _____

TEL NUMBER(S): _____

Are you working with another therapist? (If so,who?)_____

Have you had any therapy experience before? (If so, when?)

_____

Are you on any medications at this time (If so, what?)

_____

What brought you to therapy at this time? _____

How did you hear about me?

- ▫ Physician
- ▫ Non-physician referral
- ▫ Website
- ▫ Internet
- ▫ Other _____

PAYMENT POLICIES & AUTHORIZATION

I authorize my provider to collect fees for services rendered to me and/or any other persons for whom I am responsible. I agree to pay in full at the time of service unless prior written agreement has been made with my provider. I agree to provide no less than 24 hours' notice when cancelling or changing my appointments, so that others have the opportunity to schedule in my place. I understand that when I give less than 24 hours' notice for cancellations, I will be responsible for a late cancellation fee not less than $40 (not to exceed the routine cost of that appointment). I understand that failure to show for any appointment not cancelled or rescheduled prior to its start time, will result in a no-show fee of not less than 50% of the cost of the routine consult fee (not to exceed the routine cost of that appointment). I acknowledge that my provider is not a participating provider with insurance carriers and that she will not be responsible for submitting any insurance claims for me. If I choose to submit claims on my own behalf, reimbursements will be sent directly to me and not to my provider. Cash, personal checks, and credit cards (Visa, MasterCard, American Express, and Discover) will be accepted as payment when seeing this provider.

SIGNATURE: _____ DATE: _____