PeoplePsych - Client Registration

Therapist: _____

Name _____ Age _____ Gender_____

Address _____

City _____ State _____ Zip _____

Birth Date _____ Social Security # _____

Parent/Guardian (if applicable) _____Referred by: _____

CONTACT INFORMATION: (one phone number is required)

Home _____ Work _____ Cell _____

Email _____

Emergency Contact Name & Info _____ Relationship _____

INSURANCE (if applicable)

Insurance Carrier _____ Phone (required)_____

ID Number _____ Group # _____

Insured Name _____Relationship _____

☐ Address same as above

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____

Employer _____

By signing below, I affirm that I understand the basic ideas, goals, and methods of this therapy. With enough knowledge, and without being forced, I enter into treatment. The therapist has addressed my questions and/or concerns regarding confidentiality and the therapy process. I understand that no guarantees regarding the outcome of therapy can be given. This agreement shows this therapist's willingness to use and share his or her knowledge and skills in good faith. Periodically during treatment, we will evaluate progress and may change treatment goals as needed. If it becomes clear that there is a need to transition care to another therapist for any reason (e.g., the nature of symptoms being addressed, misfit of personality, lack of progress etc.) I agree to discuss these concerns with my therapist and to participate in planning for transition to a new therapist if the issues cannot be resolved.

This agreement also shows my commitment to pay for services. I agree to pay the full disclosed amount per session, and to pay at each session. I understand and accept that I am fully responsible for this fee, but that my therapist will help me in obtaining payment from any insurance coverage I have. I also understand that in order to bill a third party (insurance) confidential information such as my diagnosis, treatment goals, and treatment progress may have to be released to the third party.

I understand that 24-hour notice is required for the cancellation of a session. If 24- hour notice is not given, I understand that I may be responsible for a fee of $135, which is not reimbursable by my insurance. I understand that this charge is due in full at the time of my next session. The only exceptions are unforeseen or unavoidable situations arising suddenly.

By signing below you are consenting to receiving the psychotherapy services of PeoplePsych, LLC.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____