Client Information

Client: ____

Date of birth: ___________________ Age: ____

Address: ____ Apt.: _______________

City: ____ State: _____ Zip:_____________

Cell Phone: ___________________________ Other Phone: __________

e-mail: ____

Insurance Company: ____

Member ID: ____

Partner:

Partner: ____

Date of birth: ___________________ Age: ____

Address: ____ Apt.: _______________

City: ____ State: _____ Zip:_____________

Cell Phone: ___________________________ Other Phone: __________

e-mail: ____

Insurance Company: ____

Member ID: ____

For Minor Clients:

Name: ____

Parent's Name: ____

Date of birth: ___________________ Age: ____

Address: ____ Apt.: _______________

City: ____ State: _____ Zip:_____________

Cell Phone: ___________________________ Other Phone: __________

e-mail: ____

Insurance Company: ____

Member ID: ____

Consent to Treatment

I acknowledge that I have received, have read and understand the "Notice of Privacy Practices."

I do hereby seek and consent to take part in the treatment at Counseling ABQ.

I am aware that I may stop my therapy at any time. The only thing I will still be responsible for is paying for the services I have already received.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

______________________________________ ______________________

Signature of client (or person acting for client) Date

______________________________________ ______________________

Printed name Relationship to client (if necessary)

______________________________________ ____________________

Signature of therapist Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Cancellation Policy

Your appointment has been specifically reserved for you; therefore we respectfully require **24-hour notice of all cancellations.** Failure to give your therapist 24 hours notice of cancellation will result in a **$60 cancellation charge.** Please note that insurance companies do not pay for late cancellations or clients that do not show up for their appointments resulting in your therapist not receiving payment for that session.

Credit Card Authorization Form

We understand that things happen and sometimes you can't appear for your scheduled appointment. In that case, please call **505-220-8512** and provide 24 hour notice. If our answering service takes the call, please leave your name, your therapists name, you telephone number and information regarding canceling or rescheduling. Our therapists immediately receive a text message from the answering service. Our providers set aside valuable time just for you and we often maintain a wait list, which greatly helps us to see everyone who needs to be seen. In the event of a late-cancellation (less than 24 hours) or no-show, we will charge your credit card the $60 cancellation charge.

Thank you.

CARDHOLDER INFORMATION

Name: ______________________________

Billing Street Address: _______________________

City: _______________________________

State: __________________

Zip Code: _______________

Direct Telephone: (________) ___________ – ________________

_____ (Initials) I authorize a late-cancellation charge, in the event that I cancel with less than 24 hour notice, against my credit card for the $60 cancellation fee.

_____ (Initials) I authorize a no-show charge, in the event that I do not appear for my scheduled appointment, and I do not call (no emails please) to cancel against my credit card for the $60 cancellation fee.

If you need to cancel or reschedule an appointment, please call our office at **505-220-8512** (no e-mails please).

CREDIT CARD INFORMATION:

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number: ___________________________

Expiration Month: ___________________

Expiration Year: ______________________

Cardholder Signature: _____________________________________ Date: ______________________

Security Code: ______________________________

Counseling ABQ
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