NEWTOWN THERAPY
& WELLNESS CENTER

CLIENT REGISTRATION

Client Name: _____ Today's Date: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Date of Birth: _____Gender Identity: _____ Home Phone: _____ Cell:_____

Client's Spouse/Partner (if applicable): _____

(If Client is a Student) Name of School: _____ Grade:_____

Family Physician: _____ Psychiatrist (If applicable): _____

Current medications & dosages: _____

Person to contact in an emergency: _____ Phone: _____

Would you like to receive text reminders for your appointments the day before? Y _____ N _____

On what number? _____

FINANCIAL AGREEMENT

I have agreed to pay privately for my coaching services. All sessions are Telehealth and 45-50 minutes long for all clients. The fee is $140 per session. Paperwork and other requests such as phone calls longer than 15 minutes will be a separate cost according to the current Fee Schedule. Payment is due at the time of service. I acknowledge that Newtown Therapy will not bill my insurance company. Additionally, Newtown Therapy cannot provide a receipt with billing codes for the purposes of reimbursement through my healthcare provider, as Neurodiverse Coaching is not a medical or mental health service. There is a 24 hour cancellation policy which requires that you cancel or reschedule your appointment 24 hours in advance. Failed appointments (no cancellation) or same-day cancellations will be charged the full fee. Payments through credit cards and Venmo are accepted.

Signature: _____ Date: _____

FOR TREATMENT OF A MINOR

As the parent or legal guardian of _____, I authorize his/her evaluation and treatment by Newtown Therapy. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

Signature: _____ Date: _____