

# NEWTOWN THERAPY & WELLNESS CENTER

## CLIENT REGISTRATION

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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 mental health services. The agreed upon charge is \$ \_\_\_\_\_ for each session. The initial intake session is 60 minutes. All subsequent sessions are 50 minutes long for adults, and 45 minutes for children and adolescents, unless another arrangement is made. Testing, paperwork and other requests 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, but will provide me with a receipt for service. Additionally, I acknowledge that my insurance company may not reimburse me for Newtown Therapy services. 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.

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: \_\_\_\_\_