CultivatingChange
COUNSELING SERVICES LLC

We realize that it can often be difficult to address life's challenges and we will do our best to assist you in cultivating positive changes during your time with us. We ask that you take a few moments and fill out the information below as completely as possible. If you have any questions or need assistance please do not hesitate to ask.

Client Information Sheet

Today's Date: ____/____/_____ How did you hear about us? _____

Client's full name: _____ DOB ____/____/_____

Mailing Address: _____

Preferred Phone: (____) _____-_____ Email: _____@ _____

When contacting me please: □ do not mention agency name □ do not contact me by phone
□ do not contact me via text □ do not email me

Current Medical Conditions: _____

Reason for seeking counseling: _____
_____

Emergency Contact/Phone: _____ Relation to client: _____

If client is a minor:

Name of person bringing client in: _____ Relation to client: _____

I certify that I have the legal right to seek treatment and authorize Cultivating Change Counseling Services, LLC to provide treatment to the above named minor. I also understand, as the party authorizing treatment, that I am responsible for payment of any and all services provided.

Signature: _____ Date: _____/_____/_____

☐ Check here if you would like to be notified about upcoming workshops, events, etc. to we may provide
Please notify me via: mailing address email text

Responsible Party and Payment Information

In order to keep costs as reasonable as possible, agreed payment is required at the time of service. For billing purposes, our policy is that you provide a credit/debit card number for us to keep on file. This card can be used for session payment at your request, and may be used to obtain payment for any past due balance once we receive your insurance statement or you complete treatment. This card may also be used to charge for any no-show fees (see Cancellations / Missed Appointments policy). All credit card information will be kept in your secure electronic chart.

Card Number: _____-_____-_____-_____ Exp. Date: _____/_____ CVV: _____

Name on Card: _____ Zip Code: _____

Email/Text for Receipt: _____

Signature: _____

☐ **Insurance:**

Provider: _____ID#: _____ Group#: _____

Name of person holding the insurance policy: _____ ☐ Same as client

DOB: ____/____/_____ Relation to client: _____ Primary Phone #: (____) _____-_____

Mailing Address: _____

As a client of Cultivating Change Counseling Services, LLC, I authorize all pertinent billing information to be released to the insurance provider and responsible party listed above. I also understand that I may be responsible for any balance denied by insurance.

Signature: _____ Date: ____/____/_____

☐ **Out of Pocket: (if not using insurance)**

Annual Household Income: _____ # of dependents: _____ Per Session Fee: $_____

As the responsible party, I understand that I am responsible for payment of all services provided and agree to pay the fee listed above.

Signature: _____ Date: ____/____/_____