MANN
COUNSELING GROUP

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CLIENT REGISTRATION

(PLEASE PRINT) Date ___ /___ /___

Client's Full Name _____

Home Address _____ City_____ Zip _____

Home Phone _____ Work _____ Cell _____

Indicate by starring preferred number, and circle whether I may leave a voicemail or text: Yes or No

Email (if the client is a minor the parent/guardian's email) _____

Date of Birth of Client ___ /___ /___

IF YOU ARE A MEMBER OF AETNA, PLEASE PROVIDE A COPY OF YOUR CARD AND THE DATE OF BIRTH OF THE PRIMARY INSURED (IF PRIMARY INSURED IS NOT A CLIENT) ___ /___ /___

In case of emergency notify _____ Relationship _____

Phone _____

Marital Status of the Client _____ If married, spouse's name _____

Names and ages of immediate family members (children, siblings):

_____

_____

If adult client is single/divorced, please name resources/support systems _____

_____

Please provide the name and address of the person who referred you so that I can thank them personally, unless you would prefer not to:

_____

(Please sign here, if I may do so. _____)

Please describe the concerns that bring you into counseling at this time; (if you are a guardian of a minor, please indicate the concerns regarding the minor.)

_____

_____

Please list the medications the client is currently taking _____

(I will ask more about the client's need for counseling and relevant history during our initial session.)

CONFIDENTIALITY: The confidentiality of your discussions with the therapist is protected by ethical standards of practice and by law. The law does require, however, that the therapist must notify relevant others if a client expresses the intention to harm himself/herself or others. Instances of child abuse, neglect or molestation against a minor must also be lawfully reported.

PAYMENT POLICY: PAYMENT OF ALL FEES/CO PAYS IS EXPECTED AT THE TIME OF SERVICE. Medically coded receipts can be provided at the time of session.

- CANCELLATIONS OR MISSED APPOINTMENTS *(Please initial at the end of each bullet where indicated.)*
  Mutual consideration and respect are assumed. Therefore, any cancellations must be made a minimum of 48 hours prior to the appointment or on Thursday prior to a Monday appointment. Any fees for missed appointments or appointments cancelled without adequate notice will lead to full charge of missed appointment.
  Please initial ____
- In the event of illness or emergency, there will be a 50% charge posted.
  Please initial ____
- Please note that I only accept cancellations via my Executive Coordinator, Donna Wagner, who may be contacted by email or phone (you may call or text): donna@manncounselinggroup.com or by phone 303.960.9103
  Please initial ____

INSURANCE: Insurance coverage represents a contract between you and your insurance company. You are responsible for payment of service at the regular fee whether or not your insurance coverage applies. Monthly statements with all information needed to process your claim will be provided.

RELEASE AND STATEMENT OF RESPONSIBILITY I have read the above information and understand the payment policy. I authorize the release of information concerning my treatment to my insurance company. I understand that I am responsible for the full amount of my bill for services provided.

Client (or guardian, if client is a minor) name _____

Signature_____ Date_____