CLIENT INFORMATION SHEET

Cognitive Behavioral Therapy

Associates 108 N. 49th, Suite 210

402-889-2070

Therapist: Robin Zagurski, LCSW, LIMHP

PLEASE PRINT – FILL OUT COMPLETELY Date _____

Client's Name				
Address		City	State	Zip Code
Home Phone Number	Work Phone Number – If Child, Parent	Cell Phone Number – If Child, Parent		
Is it OK to contact you at home? ☐ Yes ☐ No Is it OK to contact you on your cell phone? ☐ Yes ☐ No Is it OK to contact you at work? ☐ Yes ☐ No				
Gender M F	Age	Date of Birth	Check One: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Widowed ☐ Living Together	
Client's Employer or School		Client's Social Security Number		
Name of Spouse (or Custodial Parent)		Client's highest Level of Education		
Spouse or Parents' Employers		Work Phone (Spouse or Parents)		
Physician Name		Medication Client is Taking		
Major Medical Conditions				

Names of Children	Date of Birth	Age	Lives With You?
_____	_____	_____	☐ Yes
_____	_____	_____	☐ Yes
_____	_____	_____	☐ Yes
_____	_____	_____	☐ Yes

Referred By	In Case of Emergency Notify
Religion Preference	Relationship to Client and Phone Number
Is Client or anyone else in family receiving counseling?	
Reason for seeking service	

CONSENT TO TREATMENT Both parents must sign if divorced and have joint legal custody of minor.

I, _____, consent to treatment for therapy/counseling for
Your Name

( ) myself or ( ) minor _____

by (Therapist / Dr.) _____

I grant this psychologist / therapist / physician to perform those procedures and treatment necessary for my condition that are generally used in this and similar settings.

_____ _____

Signature of Client or Responsible Party Date

_____ _____

Signature of Co-responsible Party Date

INSURANCE INFORMATION FORM

INSURANCE POLICY HOLDER _____

BIRTH DATE _____ **SEX** _____ **SSN** _____ - _____ - _____

RELATIONSHIP TO CLIENT _____

ADDRESS IF DIFFERENT FROM CLIENT _____

CITY _____ **STATE** _____ **ZIP CODE** _____

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the necessary client records. If my insurance company requests information, I understand that I will be notified by my therapist.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to be paid to Cognitive Behavioral Therapy Associates.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance, and I also understand that Cognitive Behavioral Therapy Associates is not responsible for my insurance company's decision about payment. I hereby authorize said assignee to release all information necessary to secure the payment

I have read the above statements and agree to their terms.

_____ _____

Client's Signature/Responsible Party *(If minor)* **Date**

FINANCIAL POLICY

Thank you for choosing us as your mental health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment. You must complete your Insurance Information form prior to treatment or provide a valid insurance card.

1. If your insurance deductible has not been met, we will expect payment in full each visit. After that, we will expect that you pay your co-pay at the time of each visit. We must have these payments in order to continue to provide you with service. Method of Payment – Cash, Checks, Visa or Master Card are accepted. If you wish to have a receipt, please request at the time of payment.
2. Adult clients are always responsible for either full payment or co-payment at time of service. The adult accompanying a minor is responsible for payment also at the time of service. If the minor is unaccompanied, payment by cash, check, or credit card is expected.

CANCELLATION POLICY

I agree to A MINIMUM OF24 HOURS NOTIFICATION OF CANCELLATION for appointments. I understand that I WILL BE CHARGED FOR THE SESSION FOR MISSED APPOINTMENTS without the minimum notification. I understand that my therapist will discuss repeated missed appointment with me.

Please let us know if you have questions or concerns about the Financial Policy. I have read the Financial Policy. I understand and agree to the terms in the Financial Policy.

_____ _____

Signature of Client or Responsible Party **Date**

I have received a copy of this agreement _____.