CLIENT REGISTRATION *(please print)*

Client's full name: _____ Gender: _____ Age: _____

Date of Birth:___/___/___ Today's Date: ___/___/___ SS# _____

Home Address: _____

Phone: (w) _____ (c) _____ (h) _____

Email: _____

Client Employer/School: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION

Full Name: _____ Relationship _____

Home Address: _____

Place of Employment:_____

Phone: (w) _____ (c) _____ (h) _____

CBT Pinellas, LLC rate for the initial intake assessment is$200 per 90 minute assessment time. Session fees are determined based on which therapist is providing care, and the type of therapy provided. There may be a separate charge for excessive paperwork or other collateral (doctors, counselors, family members) contacts if needed beyond the allotted session time. Additionally I understand that my insurance will not reimburse me and that CBT Pinellas, LLC will not bill the insurance company, but will provide an statement by the middle of the following month of services rendered, for clients of CBT Pinellas to submit for reimbursement if requested. I understand I am responsible for the full amount of my bill for services provided and there will be a $100.00 cancellation fee if the session is not cancelled within 24 hours of the originally scheduled time. I understand however, a 48 hour notification of cancellation is preferable. I am aware of the HIPAA regulations and understand my rights regarding the same.

_____ _____

Signature Date

_____ _____

Responsible Party Signature Date

CBT Pinellas, LLC
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www.cbtpinellas.com