



## New Client Information - Adult

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### Information:

I am currently employed  full-time  part time at:

Employer/Company Name \_\_\_\_\_

City, State : \_\_\_\_\_

Hours I work: \_\_\_\_\_

Please describe any current concerns you have regarding your employment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I am currently attending school:  full-time  part time at: \_\_\_\_\_

General class schedule: \_\_\_\_\_

\_\_\_\_\_  
Major: \_\_\_\_\_

Highest level of education completed:  High School  Junior College  College/University  Trade

Degree(s): \_\_\_\_\_

Please describe any current concerns you have regarding your schooling: \_\_\_\_\_

\_\_\_\_\_



Is there someone at school that we may contact?

Name, Title \_\_\_\_\_

Telephone , Email address \_\_\_\_\_

I am living independently (in my own home/apt.)

I have a roommate/housemate and share expenses. \_\_\_\_\_

I am married. Number of years? \_\_\_\_\_

I am divorced. \_\_\_\_\_

I have children.

I am responsible for my own expenses. \_\_\_\_\_

I get financial assistance for my expenses.

I am living in my parent's home. \_\_\_\_\_

I have other living arrangements.

I have been diagnosed (please include the name of the person who gave you the diagnosis and the date you received it):

\_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

On a separate sheet, please write a one page description of why you are seeking assistance from our clinic.



## Clinic Policies– Very Important, Please Read and Initial

I agree to follow the fee schedule and policies for \_\_\_\_\_ as noted:  
( print your name)

Therapy sessions: \$125 per 60-minute session for 2-5 students, \$135 for 1-2 students, \$140.00 for individual session.

Additional consultation: \$155.00 per hour for consultation with parents, report writing, IEP attendance (travel time is billed as well), phone calls exceeding 10 minutes with a therapist.

Please Initial Each Section

### \_\_\_ Absences and Missed Session

Each clinic participant is allowed 2 cancellations over the course of the school year without being billed for those cancellations, if your child started therapy with us in the Fall. If your child started therapy with us after January 31st, the child is allowed 1 cancellation. Cancellations may be due to illness, schedule conflicts, vacations, etc. Beyond these 2 cancellations, you will be billed for missed sessions. If cancellations persist, you will be asked to give up your spot in the clinic. I understand that notification of temporary absence from therapy for illness, vacation, etc., must be given 24 hours in advance if possible and not later than 7:30 am on the morning of the scheduled appointment.

The clinic closes during the 2 days of Thanksgiving, the 2 weeks of the winter holiday (December-Jan), and we are closed for the following holidays: Labor Day, President’s Day and Memorial Day. We are open for Veteran’s day and Martin Luther King Day. We run the weekly sessions until school closes again in June. If you find you cannot continue at the clinic for any reason, we require a two week notification of withdrawal to allow our staff to fill that slot. Your deposit will be applied to the last two sessions. If you are unable to provide a two week notification of withdrawal, your deposit will be applied to cover a two week notification.

### \_\_\_ Policy for most of the group being absent one week

When the therapists work in the group, they observe small details that they wish they had time to cover more intimately. When all the other clients in the group are absent, we will see you individually, at the same price as if it was a group session. This is an excellent time for receiving individual feedback and encouragement.

### \_\_\_ Policy for processing insurance claims or other administrative tasks:

We are a “private pay” clinic, meaning that all of our services must be paid for by the guardians of the client, or the adult client themselves. We do not accept 3rd party reimbursements.

### \_\_\_ Policy for billing:

Billing statements/invoices are issued at the end of each month for weekly therapy sessions. Payment is due by the 15th of the month.

Please sign below and bring these pages to the clinic on the first day of your session. Copies of these policies will be available for you to take for your reference.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_