501 S. Carroll Blvd. Suite 122, Denton, TX 76201
940-380-1600 phone 940-383-1605 fax
Freshperspectivescounseling.com counseling@fpcounseling.com

Name: _____ Date of Birth _____ Age: _____
(First) (Last) (Initial)

___ Male ___ Female ___ Married ___ Single ___ Other

Mailing Address _____

_____ _____ _____
City State Zip

May I mail correspondence to your mailing address? _____ Yes _____ No

Home Phone _____ Cell Phone _____

Work Phone_____ E-mail Address _____

Place of Employment _____May I call your place of employment? _____ Yes _____ No

Who referred you? _____

Who may I contact in case of emergency? _____ Emergency phone number _____

My hourly fee is $115.00. I accept checks and cash. For individuals and families unable to pay the fee at each session, please discuss your difficulty with me prior to the session. If you are on a managed care plan, I can provide you with an invoice which you may submit to your insurance company for reimbursement. Due to scheduling demands, I require a 24-hour notice to cancel a session. Otherwise you may be charged for the session. I understand there can be emergencies that will prevent you from giving appropriate notice. In these cases, I may not require payment. Initials: _____

Client's Informed Consent

I understand that during counseling, issues may be discussed that could be upsetting in nature and this may be necessary to help me resolve my problems. I understand records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand state and local laws require my therapist report all cases in which there exists a danger to others or myself. I understand there may be other circumstances in which the law requires my therapist to disclose confidential information. If I have insurance I understand it is my responsibility to file for reimbursement from my insurance company. Fresh Perspectives Counseling will supply a receipt providing the necessary information to process the claim. I agree to pay my counseling fees as arranged or at the beginning of each counseling session. Should a third party other than insurance agree to pay for my sessions, I agree to allow Fresh Perspectives Counseling to release billing information to the third party.

If I do not seek counsel at Fresh Perspectives Counseling for a six month period of time or longer, I understand the status of my file will be "closed". If I choose to re-establish counseling at a later time, I will be necessary to complete new paperwork for my file.

I have read and understand the above conditions of my treatment and agree to their content.

_____ _____
Signature of patient, parent, or guardian Date