BRIDGES COUNSELING
CENTER FOR CHILD & FAMILY WELLNESS

Client Name _____ **Date Of Birth:**_____

Primary Phone: _____ **Email:**_____

Address_____ **City/State/Zip**_____

PAYMENT RESPONSIBILITY:

☐ Self ☐ Other: _____Phone:_____

PAYMENT POLICY:

- Payment for services is due at the end of each session, directly to your therapist. The amount due per session was explained prior to the initial appointment and was also outlined in the email confirmation you received. Bridges Counseling reserves the right to put treatment on hold for any unpaid balances.

CANCELLATION POLICY:

- Scheduled appointments **require at least 24 hours advanced notice** to cancel or reschedule. Clients will be billed an out of pocket expense of **$100. for "no show" or late cancelled appointments.** Time slots are specifically reserved, and unable to be alternately used without proper notice. Your therapist is always open to rescheduling appointments to avoid these fees.

PRIMARY INSURANCE INFORMATION: All in and out of network clients will receive courtesy claim submissions.

Insurance Co: _____ Member ID #_____

Policy Holder: ☐ Self ☐ Other: _____Birthdate:_____

Address *(if different than client)* _____

Phone: _____ Relationship to client: _____

I authorize the release of any clinical, benefits or other information between Bridges Counseling and my insurance company that is necessary to process insurance claims for me or my dependents. Clinical information may include current and/or past symptoms, previous mental health treatment, diagnosis/diagnoses, treatment plan and/or goals, progress reports, copies of clinical notes or other clinical information.

I authorize payment of health insurance benefits to Bridges Counseling for services.

I understand that I am financially responsible for all services rendered by Bridges Counseling that are left unpaid after all insurance reimbursements have been applied.

I accept and acknowledge the above policies and certify that all the information I have provided is accurate to the best of my knowledge. If any information changes, I will provide updates as soon as possible.

X_____ _____

Client / Responsible Party Signature ***Date***