BUCKS SUPPORT SERVICES

17 BARCLAY STREET, NEWTOWN, PA 18940

CLIENT REGISTRATION FOR GROUP

Client Name: ____ Today's Date: _______________

Home Address: ___________________________ City: _____________ State: _________ Zip: ________

Email Address: ____

Parent Email Address: ____

Date of Birth: ____________ Sex/Gender: _________ Home Phone: _____________ Cell: _____________

(If Client is a Student) Name of School: ___________________________________ Grade:_____________

Family Physician: _____________________ Psychiatrist (If applicable): _________________________

Individual Therapist: ______________________________ Therapist's Contact: _____________________

Current medications & dosages: ____

Person to contact in an emergency: ________________________________ Phone: _________________

FINANCIAL AGREEMENT

I have agreed to pay privately for my mental health services. The agreed upon charge is $_________ for each group session. Additionally, I acknowledge that my insurance company may not reimburse me for services provided by Bucks Support Services.

PLEASE MAKE ALL CHECKS TO "Bucks Support Services" for payment. Credit Card Form available as well.

Signature: ____ Date: _____________

FOR TREATMENT OF A MINOR

As the parent or legal guardian of _____________________________, I authorize his/her/their evaluation and treatment by Bucks Support Services. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

Signature: ____ Date: _____________

COMMUNICATION AGREEMENT

I agree to allow for **email and text communications** between Bucks Support Services and myself and/or my child. I understand that such communications cannot be considered completely confidential.

Signature: ____ Date: _____________