BUCKS SUPPORT SERVICES

17 BARCLAY STREET, NEWTOWN, PA 18940

CLIENT REGISTRATION

Preferred Name : _____ Today's Date: _____

Legal Name If Different: _____ Pronouns: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Date of Birth: _____ Gender: _____ Home Phone: _____ Cell: _____

Client's Spouse/Partner (if applicable): _____

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

Family Physician: _____ Psychiatrist (If applicable): _____

Current medications & dosages: _____

Person to contact in an emergency: _____ Phone: _____

Would you like to receive text reminders for your appointments the day before? Y _____ N _____

On what number? _____

FINANCIAL AGREEMENT

I have agreed to pay privately for my mental health services. The agreed upon charge is $_____ for each session. The initial intake session is 60 minutes. All subsequent sessions are 50 minutes long for adults, and 45 minutes for children and adolescents, unless another arrangement is made. Testing, paperwork and other requests will be a separate cost according to the current Fee Schedule. Payment is due at the time of service. I acknowledge that Bucks Support Services will not bill my insurance company, but will provide me with a receipt for service. Additionally, I acknowledge that my insurance company may not reimburse me for services at the Bucks Support Services. There is a 24 hour cancellation policy which requires that you cancel or reschedule your appointment 24 hours in advance. Failed appointments (no cancellation) or same-day cancellations will be charged the full fee.

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: _____