CATHERINE COCHRAN COUNSELING, PLLC

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Application and Contract Form

Family Members (The client first & anyone living at home):

Name	Relationship	DOB	Medications
	Self		

Address: _____

Home phone: _____ **Cell:** _____

Work: _____

DOB: _____ **Social Security Number:** _____

Email Address: _____

Referred by: _____

Emergency Contact: _____ **Phone:** _____

Please complete if using insurance:

Insurance:	Effective Date:
Name of Insured:	Relationship to Insured:
Group Number:	ID Number:

Please complete if using EAP (Employee Assistance Program):

EAP Company:
Authorization Number:

By signing this contract, you (the client) agree to:

- receive therapy services
- a fee of $150 for assessment and $110 for subsequent sessions (other insurance rates may apply)
- my chart will be closed after 60 days of inactivity
- the exchange of any necessary information to third parties including my insurance company, billing company and/or attorney (for the purpose of collecting all fees)
- authorize payment of medical benefits to the undersigned provider for all services being rendered
- having received a copy of the Clients Rights and Disclosure Form

Client or Guardian's Signature: _____ Date: _____

Counselor Signature: _____ Date: _____