New Beginnings Counseling Center

31526 Railroad Canyon Road Suite 3Canyon Lake, CA 92587

New Client Registration Form

Therapist/Life Coach

Holistic Health Therapist, Clinical Hypnotherapist, Certified Life Coach

Please Print Neatly

Client Name	1st session date couple ☐ individual ☐
Street Address	Date of Birth
City, State, Zip Code	Cell Phone
Gender ☐ Male ☐ Female	Emergency Contact Person Relationship to Patient
Marital Status	Emergency Contact Number
Primary Physician	Psychiatrist
Physician Phone	Psychiatrist Phone
How did you hear about us? ☐ Yelp ☐ Google ☐ Maps ☐ Other:_____ ☐ Dr Uhler ☐ Relative or Friend Name_____ ☐ New Beginnings Website	

Responsible Party is the person who will be paying the fee(s) for services rendered

Responsible Party and *(Relationship to patient)* *( )*	Street Address
Preferred Contact Number	City, State, Zip Code
Email Address	**Text Message Number**

I give my permission to be sent emails and text messages from New Beginnings Counseling Center, LLC.

Yes ☐ No ☐ Patient Initials _____

Responsibility For Charges

I understand that payment of $300 for the Initial Session and $180 for Subsequent Sessions is due at the time of the visit. I agree that I will be responsible to pay for the full visit charge if I miss or cancel an appointment without 24-hour notice. It is my understanding that payment can be made through Cash, Venmo, Zelle, or credit/debit card. There will be a 3.9% charge for all payments other than cash as the surcharge for processing the payment.

Account Name Venmo: Rita-Andersen-Mitchell

Zelle Phone Number ID: 951-496-7961 ***(May come up as Mark Mitchell)***

THERAPY AND COACHING LIABILITY WAIVER

This waiver of liability includes any risk of attending sessions, engaging in Zoom sessions, group meetings, or attending any events, workshops or other services provided by New Beginnings Counseling Center.

- **C**lients using New Beginnings Counseling Center's services will understand that these services are not offered as a substitute for clinical mental health care or medical care and are not intended to diagnose, treat, or cure any mental health or medical conditions. You should also understand that their therapist or coach is not acting as a medical professional.
- **Y**ou understand and agree that you are fully responsible for your own well-being during your coaching and therapy sessions, and subsequently, your choices anddecisions.
- **Y**ou understand that all comments and ideas offered by a therapist/coach are solelyfor the purpose of aiding you in achieving your defined goals to improve or enhance your mental well-being or mental maintenance. You will be able to give informed consent, and hereby give such consent to your therapist/coach to assist you in achieving such goals.
- **Y**ou have read and understood the terms and conditions, Privacy Policy and otherdocumentation relating to confidentiality and adult protection.
- **Y**ou have understood that the use of technology is not always secure and accept therisks of confidentiality in the use of email, text, phone, Zoom, and other technology.
- **Y**ou hereby release, waive, acquit, and forever discharge your therapist/coach, any agents, successors, assigns, personal representatives, executors, heirs and employees from every claim, suit action, demand or right to compensation for damages claimed or that you may have arising out of your own acts or omissions or acts and omissions of your Therapist/Coach because of any advice given otherwise resulting from the therapeutic/coaching relationship contemplated by this agreement. You further declare and represent that no promise, inducement, or agreement not expressed in this agreement has been made.
- **N**ew Beginnings Counseling Center and your therapist reserve the right to refuseaccess to the service.

Patient Signature_____ **Date** _____

New Beginnings Counseling Center

Client Agreement of Responsibilities

As a client of New Beginnings Counseling Center, you have both rights and responsibilities that will assist us in providing you quality care that can be delivered in a courteous and sensitive manner by our therapists/life coaches and staff. Your responsibilities are as follows:

- **P**rovide ongoing honest, complete information to the therapist/Life Coach.
- **K**eep scheduled appointments and notify the office promptly if you are delayed or cannot keep an appointment. ***(The full session charge will be incurred for missed sessions or sessions without cancellation notice 24 hours in advance.)***
- **E**stablish an ongoing rapport with your Therapist/Life Coach and behave in a manner that supports the care provided to others and the general functionof the facility.
- **A**sk questions and seek clarification to understand your concerns and participate in mutually agreed upon treatment goals.
- **P**articipate in the completion of all homework assigned by the Therapist in a reasonable length of time, preferrable prior to follow-up session.
- **N**otify your New Beginnings Counseling Center staff of changes in address, phone number and responsible party for payment in a timely manner.
- **Be present without the use of mind changing substances such as alcohol or non-prescribed drugs.**
- **Make payment** of all services **at the time service is provided** unless prior arrangements have been made in writing.

I,_____, understand and agree to the responsibilities as stated.

Signature of Client_____ **Date**_____

Print Name_____

Credit Card Authorization Form

MUST BE COMPLETED TO BE SEEN BY THERAPIST

Please complete all fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until cancelled in writing.

Credit Card Information	
Cardholder Name (as shown on card)	Complete Billing Address
Card Number	Phone Number
Expiration Date (mm/yy)	Email
Cardholder ZIP Code	CVV Code
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX	

I,_____, authorize NEW BEGINNINGS COUNSELING CENTER to charge my credit card above for agreed upon services or purchases. I understand that my information will be saved to file for future transactions on my account.

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

_____ _____

Signature Date

THERAPY GOALS

Client Name: **First / Follow-up Session Date:**

Describe in detail the problem(s) that led you to consider entering therapy.

Imagine that while you are sleeping all your problems are solved. When you wake up, how will you know that things are better? What specific changes do younotice?

What are three (3) broad goals you would like to work on during therapy.

Example: "Improve my relationship with my spouse".

1.)

2,)

3.)

For each goal listed above, describe specifically how our life will be different once you have completed therapy.

Example: "My spouse and I would communication about our problems in a peaceful and kind way; without fighting, screaming, or acting out badly to each other. We would choose to be kind to each other even when we disagree.

1.)

2,)

3.)

Any other comment or information that I would like to convey to the therapist now.

COMMENTS FROM THERAPIST / LIFE COACH ONLY