19 East Abarr Drive~Pueblo West, CO 81007
435-817-0155

Client Registration

Name:_____ Date:_____

Street Address:_____ City:_____ State:___ Zip_____

Phone Numbers: Home:_____ Cell:_____ Work:_____

May I text you general appointment information? Yes/No: Signature authorizing texts_____

May I leave voice messages at the numbers listed above? Yes/No

Email address:_____

Date of Birth:_____ Age:_____ Gender:_____

Occupation:_____ Employer:_____

Household Annual Income:_____ Highest Education Completed:_____

Client SSN#_____

Insurance Provider:_____ Policy Number:_____

Co-Pay amount:_____

Primary Care Provider:_____

Referral Source and/or How did you hear about My Therapy Matters?_____

May we contact your referral source? Yes/No (The purpose is to thank them for the referral and/or to let them know you have enrolled into treatment. No other confidential information would be shared.)

Reason(s) for seeking clinical services: _____

Have you received previous mental health treatment? Yes/No. If yes, was it helpful:?_____

What have you tried in the past to resolve the issues or concerns that bring you to therapy?_____

What are your strengths and/or motivation for treatment?_____

Current hobbies/interests?_____

Allergies?_____

Current Medications or Medical Issues? _____

Date of last Physical?_____

Advanced Directives?_____

Educational Concerns?_____

Family History of Mental Illness?_____

Social or Occupational Concerns?_____

Family or Relationship Concerns?_____

Legal Issues?_____

Financial Issues?_____

Substance Abuse Issues?_____

Are you currently having suicidal thoughts?_____

Have you had suicidal thoughts in the past? If so, when:_____

Are you currently having homicidal thoughts?_____

Do you currently feel threatened or in danger of being harmed?_____

What else would you like me to know at this time?_____

Authorization to Release Medical Information and Financial Agreement
I authorize the release of protected health information to my primary care provider and insurance company for the purpose of coordination of care and to process my insurance claims.

The undersigned hereby agrees that in consideration of rendered services, the client or legal guardian individually, jointly, and severally obligates him/herself or themselves to pay the account of Clive Hallam, LMFT with My Therapy Matters. The agreed upon fees are as stated on the summary of benefits or charges given to me this day. I understand that financial obligation is my/our responsibility as the client/guardian and should the insurance company deny any payment or I/we default on payment arrangements the undersigned agrees to pay reasonable attorney fees and collection expenses should the account be referred to a third party for collection.

_____ _____
Client/Parent (or Guardian) Signature Date

_____ _____
Clive R. Hallam-LMFT, MBA Date