Maryville, TN 37803
Phone: 940-300-9933
Freshperspectivescounseling.com counseling@fpcounseling.com

Client Name: _____ Date of Birth _____ Age: _____

___ Male ___ Female ___ Married ___ Single ___ Child ___ Other

Mailing Address _____

_____ _____ _____
City State Zip

May we mail correspondence to your mailing address? _____ Yes _____ No

Home Phone _____ Cell Phone _____

Work Phone_____ E-mail Address _____

Place of Employment _____May we call your place of employment? _____ Yes _____ No

Who referred you? _____

Who may we contact in case of emergency? _____ Emergency phone number _____

For private pay clients my fee is $85.00 per hour. I accept checks and cash. For individuals and families unable to pay the fee at each session, please discuss your difficulty with me prior to the session. If you are on a managed care plan, I may be in-network with your insurance plan. It is your responsibility to confirm in-network status before sessions begin. Due to scheduling demands, I require a 24-hour notice to cancel a session. Otherwise you may be charged for the session. I understand there can be emergencies that will prevent you from giving appropriate notice. In these cases, I may not require payment. Initials: _____

Client's Informed Consent
I understand that during counseling, issues may be discussed that could be upsetting in nature and this may be necessary to help me resolve my problems. I understand records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand state and local laws require my therapist report all cases in which there exists a danger to others or myself. I understand there may be other circumstances in which the law requires my therapist to disclose confidential information. I understand if I have a managed care insurance plan that offers reimbursement to Fresh Perspectives Counseling, I must indicate this at the time I complete my initial paperwork, and call my insurance company to authorize sessions to cover therapy. If I have traditional insurance, I understand it is my responsibility to file for reimbursement. Fresh Perspectives Counseling will supply a receipt that will have the necessary information needed to process the claim. I agree to pay my counseling fees as arranged or at the beginning of each counseling session. Should a third party other than insurance agree to pay for my sessions, I agree to allow Fresh Perspectives Counseling to release billing information to the third party.

I have read and understand the above conditions of my treatment and agree to their content.

_____ _____
Signature of patient, parent, or guardian Date