Patient Registration

PATIENT'S NAME _____ Date of Birth_____ Age_____Sex_____

Address _____ Email _____

Home Phone _____--

SPOUSE'S OR PARENT'S NAME_____Date of Birth_____
Age_____

Cell Phone__(_____)_____-_

CLOSEST FRIEND OR RELATIVE, NOT LIVING AT YOUR HOME, TO CONTACT IN EVENT OF EMERGENCY

Name_____Relationship_____ Phone(_____)_____

Address_____

PARTY TO TAKE FINANCIAL RESPONSIBILITY FOR COUNSELING (If same as "patient" indicate "self")-Must sign at bottom

Name _____

REFERRED BY_____

INSURANCE

Heather Pearman MFT's policy is that **ALL FEES FOR COUNSELING ARE TO BE PAID IN FULL AT THE END OF EACH SESSION.**

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment at the time of service. I agree to pay all charges for myself, and members of my family, promptly upon presentment of statements of service, unless credit arrangements are agreed upon in writing. **I AGREE TO PAY $50 CHARGE FOR EACH RETURNED CHECK.**

The person signing this form understands that if for any reason Heather Pearman is asked to provide and/or supply documents for court, the client agrees to pay the hourly wage of $200.00 per hour for all preparations. If subpoenaed, said client agrees to pay Heather Pearman an hourly rate of 200.00 for all preparation, travel time and time spent at the CourtHouse. Client agrees to pay the hourly fee of 200.00 for all time spent preparing for deposition and time spent in deposition. The client agrees to pay these fees prior to the deposition date/court date given and realizes that Heather Pearman is not responsible for the outcome of the case.

I give permission to allow referring persons or agencies to be thanked for referring me to Heather Pearman MFT, I further give permission to Heather Pearman MFT to place my name on her text list/emailing list so that I may be informed of upcoming events, services or resources. Heather Pearman MFT's mailing list will not be given or sold to any other individual or agency.

[For Couples/Marital or Family Counseling both partners/parents must sign]

I understand that all **CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A FULL CHARGE WILL BE MADE**.

I will be fully responsible for such charges.

Signature(s) Parent or Legal Guardian if minor Spouse Sig _____

Date_____