Patient Information
(Please print clearly)

PATIENT'S NAME _____ Date of Birth _____ Age _____ Sex ____
Last First Middle

☐Minor ☐Unmarried ☐Married ☐Separated ☐Divorced ☐Widowed

Address _____ Cell # _____
Number & Street City State Zip

Occupation _____ Work # _____

Patient's Employer _____ Email _____
Name

_____
Employer Address

SPOUSE OR PARENT'S NAME _____ Date of Birth _____ Age _____

Spouse or Parent's Employer _____ Cell # _____
Name

_____
Employer Address

_____ Work # _____ Email _____
Occupation

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

Name _____ Phone # _____
Last First Middle Relationship

Address _____
Number & Street City State Zip

REFERRED BY _____ Phone # _____
Name Address Relationship

Have you or any member of your family ever been treated by Building Bridges CC? ☐No ☐Yes When (approximately) _____

INSURANCE

Building Bridges Christian Counseling's policy is that **all fees for counseling are to be paid in full at the time of each session.** Any exceptions must be made in writing. We are willing to assist in your efforts to bill your insurance carrier. If you are seeing a pre-licensed counselor it is very likely that your insurance carrier will not cover services rendered by the pre-licensed counselor.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment for 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 me and members of my family shown by statements, promptly upon presentment, unless credit arrangements are agreed upon in writing. I agree to pay a $20 charge for each returned check.

I give my permission to **allow referring person or agency to be thanked** for referring me to Building Bridges Christian Counseling. I further give permission to **place my name on the mailing list** so that I may be informed of upcoming events, services, or resources. **Building Bridges CC's** mailing list will not be given or sold to any other individual or agency.

I understand that all CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A CHARGE OF $45 WILL BE MADE. I will be fully responsible for such charges.

Signature(s) _____ Date _____

Signature(s) _____ Date _____