Client Registration

Last	Fir	est	MI	Toda	y's Date
	SSN:		Marital Status:		
		Q*.			
Street		City	S	tate	Zip
	E-	-mail:			
	Wo	ork Phone:			
choosing to SE	LF-PAY indic	cate so by omitting	g insurance i	nformati	on.
Responsibl	e <mark>Payer</mark> if dif	ferent from Poli	cyholder:		
First	MI	Relation to F	Patient	DO	В
				A	1
	En	City nail:			Zip
n.:					
Primary P	olicynolaer	Insurance Ini	ormation		
ime:			DOB:		
	80	Policyl	Policyholder SSN:		
			Phone:		
s:	1				
		City Grou			-
nformation I hav	e provided wi	th regard to my ir	nsurance cov	erage is	correct and
	-		,		
			Date:		
	Choosing to SE Responsible First Primary P me: information I have his authorization above name care vider named for sary to process to the sary to the sary to process to the sary to the sary to the sary to process to the sary to the sary to the sary to the sary to the s	Last Firest SSN:	Last First SSN:	Last First MI SSN: Marital St Street City S E-mail: Work Phone: choosing to SELF-PAY indicate so by omitting insurance it Responsible Payer if different from Policyholder: First MI Relation to Patient City Sta Email: Sta Primary Policyholder Insurance Information me: DOB: Policyholder SSN: Phone: S: City S Group Plan #: formation I have provided with regard to my insurance coven this authorization to be used in place of the original. This authorization to be used in place of the original. This authorization ramed for professional services and I authorize payment of the process this claim.	Last First MI Toda SSN: Marital Status: Erect City State E-mail: Work Phone: Choosing to SELF-PAY indicate so by omitting insurance information Responsible Payer if different from Policyholder: First MI Relation to Patient DO City State Email: Primary Policyholder Insurance Information me: DOB: Policyholder SSN: Phone: SS: City State Group Plan #: Information I have provided with regard to my insurance coverage is his authorization to be used in place of the original. This authorizatic above name carrier at any time in writing. I authorize payment of my vider named for professional services and I authorize only the release sary to process this claim.

Financial Agreement

Patient's Name:					
Last	First	MI			
Responsible Party:					
Last	First	MI			
	Fees and Cancellation Policy				
	encies, a minimum of 24 hour notice is re- responsible for a MISSED appointment for missed appointments.				
	Payment Agreement				
Lauthorize Karen Hol	obs, L.P.C, to release information to my in	nsurance carrier			
	isibility for this account and guarantee page				
against this account.	, and the second	y			
	tur <mark>ned check char</mark> ge is \$35.00. I understa	nd that, if a check is			
	ash or a money order must be used for fut				
	ccount is delinquent if the client has not p	•			
	n notice of the balance due. Every month				
will be a charge of \$1	0.00 for the processing. Any portion of th	ne account balance over 90			
days old is liable for s	subm <mark>ission t</mark> o a collection agency and sub	eject to a monthly finance			
charge of 1.5%.					
• It will be my responsi	bility <mark> to pay</mark> any collection costs.				
• I understand that for e	each NO SHOW 45 minute counseling se	ession, I am responsible for			
payment of \$50.00 .					
• If I choose to SELF- !	PAY I acknowledge a charge of \$	for each session.			
•	edit card, cash, or money order.				
• The deductible for my	insurance provider is \$ I ag	gree to pay it at each visit.			
• If there has to be a court appearance, the fee is \$2,500 per day. Whoever is the one who					
subpoena the clinician	n is the one responsible for payment 10 da	ays prior to court.			
I	the undersigned	ed have read, understand,			
PRINTED N	IAME				
and agree to all the terms, and	d conditions of this financial agreement:				
Signature of Responsible Pa	ayer:	Date			

INFORMED CONSENT FORM

Client's Name	Date	DOB					
This informed consent document provides general information about the counseling services offered by Karen Hobbs, L.P.C., Renewing Hearts Family Counseling, L.L.C., and designated graduate students. This is a legal document; please read it carefully before signing.							
• Nature of Counseling: The type and eximitial assessment and thorough discussion with a that there may be both benefits and risks associatimprove ability to relate to others, provide a clear ability to deal with everyday stress. I understand and change, which might have an unexpected improved the country of the country	me (or my child) and the assigned with participation in counsing understanding of self, valuation that counseling may also lead	ned counselor. I understand eling. Counseling may es, and goals, and an to unanticipated feelings					
• Supervision: I understand that Jennifer Marriage and Family Therapy through Liberty U second supervisor who is a License Marriage and Patricia Profit and Matthew Stevens have complethrough Liberty University. They are completing receive supervision and mental health counseling L.P.C., Clinical Supervisor.	niversity. I understand that Jer I Family Therapist which is re eted a Master's degree in Profe residency requirements for V	nnifer Runner, M.A. has a quired for licensure. essional Counseling irginia licensure. They					
• Confidentiality: I (the client) understand that counselors maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. The results of the Internship student's work with me/my child require that personal information be discussed with Karen Hobbs, L.P.C. As well, exceptions for intent to harm self or others, suspicion of elder abuse and/or neglect, suspicion of child abuse and/or neglect, or if a Judge from a Court of Law requests legal documentation requiring disclosure of information to official parties as designated. Should questions arise regarding this consent form or services offered - I understand that I may discuss them with my/my child's counselor. I have read and I understand the above. I understand that treatment may be stopped at any time and there are no penalties for denying permission to counsel. I also understand that I can request to meet with Karen R. Hobbs, L.P.C. at any time if I have any questions or concerns.							
Client's Name (please print)	Client's/Parent (if Minor) S	Signature Date					
Responsible Party Name (please print)	Responsible Party Signatur	e Date					
Clinician Signature	Karen R. Hobbs, M.A., L.F	P.C. Date					