Cloud Break Therapy

Registration Form

(Please Print)

Today's Date: _____How did you hear about us? _____

Patient's Full Name: _____ _____ _____
(Last) (First) (MI)

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: ( )_____ Age: _____ Marital Status: _____ DOB: ___/___/_____

Cell Phone: ( )_____ E-mail Address: _____

Would you like to receive Email reminders from the Cloud Break Therapy? Yes No

Present Employer Name: _____ Work Phone: ( )_____

If Student, School or College: _____

Emergency Contact: _____ Relationship: _____ Phone #: ( )_____

INSURED/ RESPONSIBLE PARTY INFORMATION

(Please complete if you are using insurance coverage)

Name of Insured: _____ Relationship: _____ SS#: _____
(Last/First/MI)

Home Address: _____

Home Phone: ( ) _____ DOB: ____/____/_____

Employer Name: _____ Employer Phone: ( )_____

Primary Insurance: _____ ID#: _____ Group #: _____

Secondary Insurance: Y N Company: _____ Policy #: _____

BILLING AND INSURANCE POLICY

1. I authorize use of this form for all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I permit a copy of this form to be used in place of an original.
6. I authorize charges to my credit or debit card in the event of a delinquent balance or a missed appointment.

Print Name: _____

Signature: _____ Date: _____

- It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance at the time of services rendered.
- There will be a $50 service charge on all returned checks.
- In the event that your account goes to collections, there will be a 25% collection fee added to your balance.
- Your credit or debit card will be charged $100.00 (not co-pay amount) automatically in the event of a missed appointment with no notification and in the case of a delinquent balance (15 days after an account statement requesting amount due has been sent).
- There is a 24-hour cancellation policy that requires that you cancel your appointment 24 hours in advance to avoid being charged a $100.00 fee. Cancellations may be made by phone, email or text message.
- I understand that if I miss three sessions with no notification then the therapist has the right to end treatment.
- I understand and accept all of the terms regarding billing and insurance policies.

Signature: _____ Date: _____

CONFIDENTIALITY

We are required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. Your insurance company paying for services has the right to review all records.
3. You voluntarily waive your rights to privilege or give consent to limited disclosure by your therapist.
4. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
5. You file suit against your therapist for breach of duty or your therapist files suit against you.
6. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
7. Your therapist is appointed by the courts to evaluate you.
8. Your contact with your therapist is for the purposed of determining sanity in a criminal proceeding.
9. Your contact is for the purpose of establishing competence.
10. Your contact is one in which your therapist is required to file a report to a public employer or as information is recorded in a public record and is open to public inspection.
11. You are under the age of 16 and are the victim of a crime.
12. You are a minor and your therapist reasonably suspects you are a victim of child abuse.
13. You are over the age of 65 and your therapist believes you are a victim of physical or emotional abuse.
14. You die and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.

** If you have any questions about these limitations, please discuss them with your therapist.

Signature: _____ Date: _____
I am consenting to my (or my dependents') outpatient treatment.