NEWTOWN THERAPY
& WELLNESS CENTER

CLIENT REGISTRATION

Client Name: _____ Today's Date: _____

Preferred Name: _____ Email Address: _____

Home Address: _____ City: _____ State: _____Zip: _____

Date of Birth: _____Gender Identity: _____ Home Phone: _____ Cell:_____

Client's Spouse/Partner (if applicable): _____

(If Client is a Student) Name of School: _____ Grade:_____

Family Physician: _____ Psychiatrist (If applicable):

_____ Current medications & dosages:

_____

Person to contact in an emergency: _____ Phone: _____

Would you like to receive text reminders for your appointments the day before? Y _____ N _____ On

what number? _____

FINANCIAL AGREEMENT

I have agreed to pay privately for my mental health services. The agreed upon charge based on session type: (Phone session $100, Virtual Therapy Session {via Google Meet} $160, In-Person therapy session $175) The initial intake session is 60 minutes. The first appointment, payment is required in advance. Once you're an established client, we'll securely charge your credit card at the time of each session going forward. I acknowledge that Newtown Therapy will not bill my insurance company, but will provide me with a receipt for service provided in PA. Additionally, I acknowledge that my insurance company may not reimburse me for Newtown Therapy services. There is a 24 hour cancellation policy which requires that you cancel or reschedule your appointment 24 hours in advance. Failed appointments (no cancellation) or same-day cancellations will be charged the full fee. Cancellation with more than 24 hours' notice are refundable, minus credit card processing fees.

Signature: _____ Date: _____

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FOR TREATMENT OF A MINOR

As the parent or legal guardian of _____, I authorize his/her evaluation and treatment by Newtown Therapy. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

Signature: _____ Date: _____