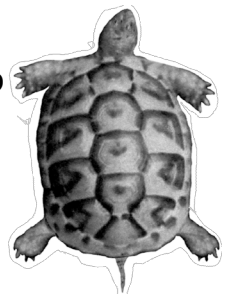


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Welcome To My Services

The following information is needed to meet State information and Insurance requirements:

Section 1 - Patient Information

Name _____ Date Of Birth _____ - _____ - _____ Age _____ Gender M of F
 Address _____ City _____ State _____ Zip _____
 Home _____ - _____ - _____ Work _____ - _____ - _____ Mobile _____ - _____ - _____
 Best Number to call? _____ Best time to call? _____ OK to call Home: OK to call Work?
 Youth Single Married Separated Divorced SSN _____ - _____ - _____
 Occupation _____ Employer or School _____
 Referred by _____ May I thank them? Yes No
 Primary Care Physician _____ Address _____ Phone _____ - _____ - _____

If the Patient is under 13 years old, please complete Section 2

Section 2 - Parent and/or Guardian Information

Name _____ Date Of Birth _____ - _____ - _____ Age _____ Gender M of F
 Address _____ City _____ State _____ Zip _____
 Home _____ - _____ - _____ Work _____ - _____ - _____ Mobile _____ - _____ - _____
 Best Number to call? _____ Best time to call? _____ OK to call Home: OK to call Work?
 Youth Single Married Separated Divorced SSN _____ - _____ - _____
 Occupation _____ Employer or School _____

Section 3 - Fee and Payment Information

PAYOR: Self Reiki . Therapy Women's Group Third Party: Insurance * DCFS Community Wellness

*PLEASE PROVIDE YOUR INSURANCE CARD TO BE COPIED FOR YOUR FILE. Copy Made For File

Third Party Portion Est. \$ _____ Client Portion Est. \$ _____ Total Fee Per Session Est. \$ _____

Section 4 - Missed Appointments and Late Cancellations

(Third party payers will not cover any part of the cost of an appointment that is either missed or canceled with less than 24 hours notice.)

THERAPIST'S STATEMENT: When you and I schedule an appointment I am setting aside a part of my schedule to offer Therapy and/or Reiki treatment for you at your request. This is a commitment I make with the utmost respect and value.

CLIENT'S STATEMENT: I understand and agree that I am personally responsible for payment of the Total Fee Per Session: \$ _____, for all scheduled sessions. This includes missed appointments and appointments canceled within 24 hours of the appointment time. I understand that I am also responsible for any additional costs for collection if necessary.

I understand that our insurance processing and billing service will process all personal information confidentially

Signed _____ Date _____ - _____ - _____

ESTE DOCUMENTO HA SIDO TRADUCIDO Y EXPLICADO EN SU TOTALIDAD.

Firma del Guardian/padres _____ Firma del traductor _____ Fecha: _____

SKAGIT FAMILY STUDY CENTER