THRIVE
COUNSELING & CONSULTING, PLLC®

NEW CLIENT SIGNATURE PAGE

NAME: **DOB (mm/dd/yy):** _____ / _____ / _____

1. The information provided on the registration is true to the best of my knowledge.
2. By my signature I authorize Thrive Counseling & Consulting, PLLC therapists to treat myself or the above-named family member. In the event that I or my family member change therapists, I also authorize the new therapist to access progress notes of topics discussed during previous sessions.
3. I have received, read, and understood the Office Policies.
4. I hereby acknowledge that I have received and have been given an opportunity to read Thrive Counseling & Consulting, PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the notice of my privacy rights, I can contact the owner of Thrive Counseling & Consulting, PLLC.
5. I understand that if I refuse treatment, my therapist shall determine whether treatment in some other modality is possible. If I refuse treatment via other modalities, I may be discharged from services.

Client Signature *Date* _____ / _____ / _____

Parent/Guardian Signature *Date* _____ / _____ / _____

Parent/Guardian Printed Name *Staff Member Signature*

❑ Client refuses to acknowledge receipt of
Notice of Privacy Practices

Thrive Counseling & Consulting, PLLC seeks to help each client achieve their goals. If you don't understand the following, please discuss with your therapist or with administrative staff before you sign.

1. Thrive Counseling & Consulting, PLLC is the corporation that does business.
2. Each individual therapist is either a contractor or employee of the above corporation.
3. It is our intention at Thrive Counseling & Consulting, PLLC that you get the help that you need. It is therefore important that your therapist is a good fit for you or your family member. **Please let your therapist know exactly what your expectations are and what changes you are looking for. Do this during your first session. If you believe at some point that it is not a good fit, we encourage you to speak to your therapist first to see if adjustments can be made.** If you discover it is still not a good fit, please ask your therapist for a referral to another therapist at Thrive Counseling & Consulting, PLLC who may be a better fit.

I have read & understood the above.

Client Signature *Date* _____ / _____ / _____

Name of Primary Care Physician/Clinic:
(if you do not agree to this, write "None" and sign below):

Client Signature *Date* _____ / _____ / _____

Please sign under ONLY ONE of these choices:

SELF-PAY CLIENTS ONLY: I attest that:

a. I do not have insurance coverage, OR

b. I have insurance coverage but choose not to use it, and in doing so I am waiving any right to reimbursement, OR

c. I have insurance coverage, but understand that my services are not covered by the plan.

d. I agree to pay the rate as disclosed in my therapist's professional disclosure.

Client Signature *Date* _____ / _____ / _____

INSURANCE CLIENTS ONLY: I authorize any insurance benefits to be paid directly to Thrive Counseling & Consulting, PLLC, or any of its contracted therapists who provide services to me or my family members. I understand that I am financially responsible for any balance. I also authorize Thrive Counseling & Consulting, PLLC (or the entities listed above) and/or insurance company to release information required to process my claims.

Client Signature *Date* _____ / _____ / _____