Breakthrough Counseling & Coaching
1616 East 19th Street, Suite 1
Cheyenne, WY 82001
P: 307-514-2781 | F: 307-514-0714

CLIENT INFORMATION:

Client Name:_________________________ Date of Birth: _______________________

Address:_____________________________ City:_______________ State:_____ Zip:__________

Marital Status:__________________ Phone Number(s)_________________________________

Email:______________________________________ Ok to Text ☐ Yes ☐ No

Client Employer:______________________________ Occupation:___________________

Emergency person to contact: _____________________________ Relationship: _____________

Phone: ______________________ Address:____

Cell or Work ___________________________________ **Text?** Yes ☐ No ☐

Does anyone have any type of Power of Attorney (POA) for you, if yes for what reason?_______________

Name of Person with POA:____________________________ Contact information for person with

POA:____

Have you been in counseling before? Yes ☐ No ☐ If yes, how long?__________________________

If yes, what was your diagnosis or what were you seen for?__________________________________

How long did you attend counseling? ____

List significant health problems:____

List any medications:____

INSURANCE CARD INFORMATION:

Checking on your insurance deductible/co-insurance is not the responsibility of Sonjia Serda, dba Breakthrough Counseling & Coaching. If a call to your insurance is required and the phone number is not provided, that may result in you paying for your services.

If you are private pay for counseling services, or if services are covered through an EAP, skip this section unless you think you will continue counseling. Please verify your deductible has been met otherwise you will be responsible for each appointment. Breakthrough Counseling does not offer outstanding balances to wait for insurance payments unless previously arranged.

Insurance Company Name___________________________ Issuer____________________________

Social Security Number_____________________________ Member ID_________________________

Full Member Name:____ Group No_____________________________

If TriCare, sponsor social security or DBN:____

Some cards have information For Members and For Providers. Provide the information "For Providers"

Phone number for Mental Health or Behavioral Health benefits____________________________________

Insurance Company Website if known ____

PAYMENT AGREEMENT – Please read & Initial Each One

_____ It is understood that payment is due at the time of service unless prior arrangements are made. I/We agree to be responsible for all charges rendered on behalf of the identified client above, including any charges not reimbursed (co-pay, deductible, co-insurance, services not covered, etc.) by my insurance carrier, unless a special arrangement has been agreed-upon in writing.

_____ It is further understood that I/We will be financially responsible for each missed appointment, unless a 24-hour notice is given prior to the scheduled appointment at the rate of $50 for each missed appointment. Insurance companies do not reimburse for missed appointments. In the case of emergency, this fee will not be charged.

_____ It is understood that Sonjia Serda, LLC is not responsible for any charges my insurance does not pay. Insurance billing is a courtesy. **I/We are fully responsible to check my insurance benefits by the first therapy appointment so I know what will or will not be covered, otherwise I will be expected to pay the self-pay rate of $110 per hour due at the time of service.**

_____ It is understood that I/We will be responsible if any checks written to Sonjia Serda/Breakthrough Counseling are returned from the bank for any reason and incur additional bank charges as well as administrative fees. Sonjia Serda charges at a flat rate of $25 per check return. If 2 checks are returned, a different form of payment will need to be established such as cash or credit card. Mailing address is PO Box 22432, Cheyenne, WY 82003

_____ It is understood that if I/We change address, phone numbers, or any other pertinent information before counseling ends, I/We will notify Sonjia Serda as soon as possible.

The signature(s) below indicate that I/We understand and agree to this Payment Agreement and that I/We will be responsible for any collection and/or attorney fees and/or court costs associated with the use of outside agencies required in the collection of my/our account.

Client Signature:____ Date:___________________________

Client Signature:____ Date:___________________________

Responsible Party Signature:______________________________________ Date ___________________________