BreakThrough Counseling
1616 East 19th Street, Suite 1, Cheyenne, WY 82001
307-514-2781

Client Information: **Form C**

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 your insurance deductible/co-insurance is not the responsibility of Sonjia Serda, dba BreakThrough Counseling/ If your deductible has not been met, they will not make any payments. You will be responsible for all counseling fees due at each appointment, $140.00 per hour, $225.00 for an initial assessment usually completed by the third appointment. Couple therapy is $175.00 per hour and family therapy is $195.00 per hour. Most insurances do not pay for couple therapy, few pay for family therapy.

Skip this section if you are private pay or if services are covered through an EAP, unless you think you may continue counseling. BreakThrough Counseling does not carry 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 $140.00 ($225.00 for initial intake) per hour or co-payment/co-insurance 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 and a different form of payment will need to be established such as cash or credit card.

_____ 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 _____