MINDFUL HEARTS THERAPY
7702 E. Doubletree Ranch Rd., Ste 300
Scottsdale, AZ 85258
520-329-7955 VLP4102@aol.com

NEW CLIENT REGISTRATION

Last Name of Patient___________________________ **First Name**_________________________ **Middle Initial**______

Address______________________________ **City**_________________________ **State**______ **Zip**____________________

Cell (____)______________________ **Home Telephone (____)**___________________ **Work(____)**___________________________

Date of Birth ___________________ □**Male** □**Female** **E-mail Address**_______________________________________

Marital Status: ___ **Married** ___**Single** ___**Separated** ___**Divorced** ___ **Widowed** **Other**______________ **Number of children**___________ **Biological**______**Adopted**______**Step-child**_________**Blended Family**__________________

NAMES of Children ________________________**AGE**_____**SEX**_____ **Relationship Status**

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Patient's Employer____**City**___________________________________

Occupation:____**Type of Business:**___________________________________

Information Pertaining to Spouse, Partner, or Significant Other:

Spouse/Partner Last Name___________________________ **First Name**_____________________________________

Street Address____________________________ **City**__________________________ **State**_______ **Zip**__________

Cell (____)_________________________**Home Telephone (____)**____________________ **Work** ____________________________

Date of Birth __________________ □**Male** □**Female** **Relationship to Patient:** _______________________________

Spouse/Partner Occupation___________________________________**Employer**______________________________

In Case of Emergency- Name and Relationship to patient____

Responsible Party Contact Phone Numbers____

Other Family Members under age 18 seeking consultation or treatment Names and Dates of Birth:

1._________________________________**3.**_________________________________**5.**__________________________

2._________________________________**4.**_________________________________**6.**__________________________

How or who referred you ____

a)Payment is due at the time of session or when services are rendered. The hourly rate is $120-135 unless you qualify for a sliding scale based on income, bottom of the scale is $50 an hour. $________

b) We do not accept or process insurance including Medicare/Medicaid, nor do we participate with any other insurance plan

c) If I file a claim on my own, except for Medicare/Medicaid, and the insurance carrier requests information directly from his provider or PCS, it is understood that this provider or Mindful Hearts Therapy, will not respond in any way to this request but will wait to hear from me, the patient or insured, and receive written permission to respond on my behalf.

d) 24-hour notification (1 business day) is required to cancel or change an appointment. I understand that if changes are made after the 24-hour period then a fee of $50 for the late cancellation or changes may be incurred.
***PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the Notice of Privacy Practices (Psychotherapist-Patient Services Agreement) and have been provided an opportunity to read and review it.**

******I consent to consultation and/or treatment for the above-mentioned person(s):**

X_____________________________ X_______________
SIGNATURE OF PATIENT DATE

X _____________________________ X_______________
SIGNATURE OF RESPONSIBLE PARTY, PARENT, OR LEGAL GUARDIAN DATE

X_______________________________________ X_________________
SIGNATURE OF CLINICIAN DATE

MINDFUL HEARTS THERAPY

7403 E. 6th Ave., Ste, #5,
Scottsdale, AZ 85251
520-329-7955 VLP4102@aol.com

Credit Card on File Agreement

As an authorized signer on the credit card listed below, I give Davis-King, LLC, permission to utilize the credit card for all charges related to and including services rendered at the offices of Davis-King, LLC. I also give consent to release necessary personal information to a third-party billing service that is responsible for collecting credit card information and completing associated billing. I understand that I may be charged a $50 fee for cancellations or changes made less than 24 hours prior to scheduled appointments.

Visa/MC Account Number: ______________________________

Expiration Date: ______________________________

Security Code or CID #: ______________________________

Billing Zip Code: ______________________________

Name on Card: ______________________________

Name of Client(s): ______________________________

Phone Number: ______________________________

Email address: ______________________________

______________________________ ______________________
Signature Date