

# Branches Recovery Center

CLIENT APPLICATION		
Name:		
Date of birth:	E Mail:	Phone:
Current address:		
City:	State:	ZIP Code:
Alt. Phone:	Preferred Contact:	SS#:
COUNSELING INFORMATION		
Counselor:		
Type of Counseling:	Hourly Fee: \$90.00	
Frequency:	Scholarship:	
Payment Type:	Name on Card:	
<b>Credit Card No.</b>		Address of Cardholder:
<b>Exp. Date:</b>		
<b>Signature Authorizing Use of Card:</b>		
EMERGENCY CONTACT		
Name of a relative not residing with you:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
SPOUSE INFORMATION IF COUPLES		
Name:		
Date of birth:	E Mail:	Phone:
SPOUSE CONTACT INFORMATION IF DIFFERENT		
Current address:		
City:	State:	ZIP Code:
Alt. Phone:		
INSURANCE INFORMATION		
Name of Insured:	SS# of Insured:	Group No.:
Address:	Employer:	Policy No.:
City/ST:	DOB of Insured:	Co- Pay:
CHILDREN IF INCLUDED IN COUNSELING		
Name		Name
Name		Name
SIGNATURES		
I authorize the verification of the information provided on this form as to my credit		
Signature of applicant:		Date:
Signature of spouse <i>(only if for a joint membership):</i>		Date:

# Branches Recovery Center

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## Consent to Treat

*Please fill out and sign / date where indicated.*

### Client:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ SS# \_\_\_\_\_

### Consent to Treat

I, \_\_\_\_\_ do hereby consent for the staff at Branches to provide services to me

( Please Print )

or to my dependent. I understand that all services are voluntary. I affirm that I am a willing participant.

*Without signature, we are unable to provide services.*

\_\_\_\_\_  
Patient / Guardian signature

\_\_\_\_\_  
Date

### Primary Care Physician

For coordination of care, we request that you provide the name of your primary care physician. We will contact your physician to inform of the services that you will receive here. This information along with your signature gives us authorization to contact your primary care physician, as required, in regards to your treatment.

*If you do not have a primary care physician or you do not want us to make contact please leave this area blank.*

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

### Referral Source

We would like to thank whoever referred you to this office. By providing the following information and with your signature, this gives us authorization to send a "Thank you" letter to the referral source from this office.

*If you do not wish us to do this, please leave this area blank.*

Person who referred you \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

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Client Name \_\_\_\_\_

## Confidentiality

This is to inform you that all services received in this office are strictly confidential. Without your written consent for release of information your participation in services provided at this office will not be confirmed or denied nor will any other information be released. There are certain exceptions to confidentiality. Please ask your service provider for more information.

\_\_\_\_\_  
Patient / Guardian Signature Date

May we call your home or work, recognizing ourselves as Branches Recovery center at :  
Home: Yes No Work: Yes No (Circle one each)

May we talk to whoever answers, recognizing ourselves as Branches Recovery center at :  
Home: Yes No Work: Yes No (Circle one each)

May we leave a message, recognizing ourselves as Branches Recovery center at :  
Home: Yes No Work: Yes No (Circle one each)

\_\_\_\_\_  
Patient / Guardian Signature Date

## Authorization for Release of Information

I hereby authorize Branches Recovery Center to furnish information to staff counselors concerning my illness and treatment. I further authorize the transfer of records from/to Branches Recovery Center and Insurance companies until such permission is canceled in writing by me.

\_\_\_\_\_  
Patient / Guardian Signature Date

\_\_\_\_\_  
Witness Date

## Cancellation/ Check Return

Please be advised that there is a **\$50** charge for appointments not cancelled at least 24 hours in advance. This charge also applies should you not show for an appointment without canceling at least 24 hours beforehand. This charge will **not** be billed to insurance. The payment for the charge is **your** responsibility. Payment for missed appointments is expected at the next office visit, and you will not be seen again until payment is received. It is your responsibility to keep up with scheduled appointments. You will not be called to remind you of your appointment. This policy ensures that you will receive timely treatment in the most efficient way possible.

We accept cash, checks or VISA/MasterCard. If you wish to pay by credit card, simply fill out the information below. Your card will be charged at the end of each session for that session only. *There is a \$20.00 fee for checks that are returned due to non-sufficient funds.*

**I have read, agree to, and understand the cancellation and check return policy.**

\_\_\_\_\_  
Patient / Guardian Signature Date

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## FEE CHART

It is the desire of **Branches Recovery Centers** to assist you by providing a professionally trained Christian counselor or life coach. To keep this Christian practice viable in your community, we ask you to use the fee chart below.

The current rate for Professional Counseling in the Murfreesboro/Nashville area is \$120 per session. Because Branches Recovery Center is a Faith Based, Non-Profit Organization, the charge for private individual counseling is \$90.00 per session. If you have an adequate income, it would be appreciated if you would provide payment in that amount.

There is a one time testing assessment fee of \$40.00 for those who choose to take the APS. This is a temperament profile which provides valuable information to the counselor and the counselee to progress more efficiently in your sessions.

For those who have lower income, the following adjustable fee guide will assist you in determining a reasonable payment for each counseling session. If you use the fee guide, you are **not required** to bring proof of income. But, if you are on a fixed income or you have extenuating circumstances that would prevent you from receiving help even at the \$60.00 level, then you may need to show **proof** of need by bringing in tax forms, excessive medical bills, child support payments, or anything that would apply to your situation in order to determine what your fee would be. The chart represents **combined family income**.

<u>YEARLY GROSS PAY</u>		<u>FEE PER SESSION</u>
00,000	To 34,999.....	60.00
35,000	To 44,999.....	65.00
45,000	To 54,999.....	70.00
55,000	To 64,999.....	75.00
65,000	To 74,999.....	80.00
75,000	To 84,999.....	85.00
85,000	and ABOVE.....	90.00

## FEE AGREEMENT

Clients are scheduled in 60 minute increments throughout the day, but the fee is set for a 45 minute session. If client needs extra time it will be charged in quarter hour increments at \$20.00 per 15 minutes and will be added to the charge at the end of client's session. The agreed fee per 45 minute session is \$90.00, unless the fee scale is used. **If the fee scale is elected, fill in the three categories below:**

Yearly combined family gross income \$ \_\_\_\_\_  
Number of family members living in your home \_\_\_\_\_  
Your Fee per 45 minute session \$ \_\_\_\_\_ **Also, circle fee amount above.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**CHECKS SHOULD BE MADE OUT TO BRANCHES RECOVERY CENTER.**