Center for Christian Counseling & Training

Patient Registration Form

Please Print

Last Name____________________________________ First Name__________________________ MI___________

Address____

City____ State____________ Zip____________________________

Social Security #________________________________ Date of Birth______________________ Sex_____________

Marital Status_____________________ Home Phone____________________ Daytime Phone__________________

Cell Phone_______________________ Home E-Mail____

Church You Attend____ Religious Preference______________________

Employer Name____

Employer Address__________________________________ City________________ State_____ Zip_____________

HOW DID YOU LEARN ABOUT THE CENTER?

Friend/Family____ Yellow Pages____ Physician____ Counselor____ Other____________________

Please Specify

Referring Physician or Counselor____

Please Specify Name

Address City State Zip Phone

RESPONSIBLE PARTY INFORMATION (if different than patient)

Last Name____________________________________ First Name__________________________ MI____________

Address____

City____ State_____________ Zip___________________________

Relationship to Patient______________ SS#____________________ Birth Date____________Phone_____________

Employer Name____

Employer Address__________________________________ City________________ State_____Zip______________

EMERGENCY CONTACT – NOT LIVING WITH YOU (i.e. friend or relative)

Last Name_________________________________ First Name_______________________ MI__________

Address____

City_______________________________________ State_____________ Zip______________________

Relationship to Patient_________________________________ Phone______________________________

BRIEFLY TELL US WHY YOU HAVE COME TO SEE US

____

____

WHAT DO YOU EXPECT TO ACHIEVE

____

____

PAYMENT

Our heart's desire is to assist you with the help of the Lord, the Word of God, our professional training and life experience. To keep this center continuing for you and for others, we call your attention to the financial matter. Our fee schedule for evaluations, counseling, and testing are below the national average. A complete fee schedule is available upon request. Additionally there are miscellaneous charges including mileage and travel time if sessions are held other than at our office location. We reserve the right to charge $25.00 for a broken appointment of less than 24 hours notice. If you are unable to pay for the total charges for counseling at this time please discuss the matter with the counselor at the start of your appointment.

Please check this box ___ if you are unable to pay the full costs prior to the session.

Please indicate how you plan to pay for this and future sessions.

___Cash ___Check ___Visa ___MasterCard ___Discover ___PayPal

I have read and understand the information contained in this form

____ ____________________

Signature Date

Center for Christian Counseling & Training

Informed Consent

I/we, ____, have been informed that the Center for Christian Counseling is a ministry and that any counseling provided will be spiritual counseling from a Biblical perspective and;

1. That Dr. Roger Boehm is an ordained minister of the Gospel and is a licensed Clinical Christian Counselor (Advanced Certification), licensed by the National Christian Counselors Association.

2. The State of Florida mandates that all professionals must report or cause a report to be made and can not keep silent on the grounds of confidentiality or privileged communication, the following:

   - When a disclosure indicated a counselee may cause danger to self
   - When a disclosure indicated a counselee may pose a danger to others
   - In case of suspected child abuse and/or neglect as required by law

3. That a free exchange of information between appropriate staff members of the Center for Christian Counseling regarding my evaluation and treatment may take place as necessary. Otherwise my file will be treated with strict confidentiality, except as noted below:

   - If I sign a release of information authorizing specific disclosures

4. That the counselee desires to take advantage of the Counselor's services and training, and understands the Bible will be the foundational basis for all counseling.

5. In consideration of the provision of services by the Counselor, the counselee agrees that the counselee will not hold Dr. Roger Boehm, The Center for Christian Counseling, or any staff member responsible for any tort, including invasion of privacy, outrageous conduct or intentional infliction of emotional distress.

6. That a staff member has explained fully to me, the counselee, all of the above prior to entering into any counseling or disclosure.

7. That I freely and willingly accept and agree to abide by this informed consent as presented.

______________________	__________	__________	______________________
Counselee Signature	Date	Date	Witness Signature

______________________	__________	______________________
Parent/Legal Guardian Signature	Date	Relationship to Counselee

Counselee Name____ Date of Birth______________

Counselee Address____

Center for Christian Counseling & Training

Office Policy

Following are our office policies. Please read thoroughly and sign below.

I understand that:

The office does not extend credit to any person, company, or institution. Payment will be received by office personnel prior to seeing the doctor.

I am responsible for payment in full for all services at the time they are rendered. I accept this ultimate responsibility whether or not or in case that third parties cover, do not cover, deny, pre-certify, pre-authorize, or authorizes procedures, services, or payment.

I will be reimbursed by the Center for Christian Counseling for any third party payment to the office for services for which I have already paid.

If I am unable to keep an appointment I will contact the Center at 269-0404 at least 24 hours prior to the appointment.

Failed appointments, failed counseling compliance, failed office policy compliance, and/or failed therapeutic alliance will result in being subject to termination by mutual consent and referral to another Counselor if requested followed by two weeks coverage for counseling emergencies**. There is a $25.00 charge for failed appointments unless 24 hours notice has been given payable prior to the next scheduled appointment.**

I am required to pay prior to the beginning of each session.

We accept cash, check, Mastercard, Discover & Visa. Payments may also be made on our website www.CenterForChristianCounseling.org using PayPal. Make checks payable to C.F.C.C. (Center for Christian Counseling).

If you have any questions concerning payments, please direct your questions to Missy our office manager. She is available Monday through Friday 9:00am to 2:30pm.

ATTENTION FEMALE CLIENTS

If you will be seeing Dr. Boehm and would feel more comfortable with a female staff member/counselor trainee in each session, please indicate by placing a checkmark in this space. ______

______________________________ ______________________________

Signature of Patient/Representative Date Witness Date