Lux Therapy Center

Bijal Patel LLC

Client Registration Form

Date: _____ Referred by: _____

Client's last name: _____First name: _____ MI _____

Birth date: _____/_____/_____ Age: _____ Sex: _____ Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Social Security No. :_____-_____-_____

Cell or home phone no: _____ May I leave a message? _____Y_____N

Occupation: _____ Employer: _____

Email: _____

Household Information: Please list the current members of your household, not including yourself

Name	Age	Relationship	Occupation/ School Grade

Must be completed by Parent/Guardian if Client is under 16 years old

Mother's last name: _____ First name: _____Custody: _____Y _____N

Telephone number: _____ Child's Status ___Biological ___Adopted ___Stepchild ___Foster ___Other_____

Father's last name: _____ First name: _____Custody: _____Y _____N

Telephone number: _____ Child's Status ___Biological __Adopted ___Stepchild ___Foster ___Other_____

Please list any other legal guardians:

Name: _____ Telephone number: _____

Billing Information

Kindly take the time to read each statement and initial that you acknowledge and agree.

Payment: All payments must be made at the time of service. We accept cash, check, Visa, or MasterCard.	
Non-Payment: Any balance accrued must be paid within 7 days, otherwise services may be suspended.	
Missed Appointments: Because your appointment time has been reserved specifically for you, a minimum of 24 hours notice is required for re-scheduling or cancelling an appointment. If 24 hour notice is not given, please be aware you will be charged for a full session. We understand that on occasion, issues may arise causing you to miss your appointment without the ability to notify the office prior to your appointment; should this arise, please contact us as soon as possible so we may come to an agreement for the session missed.	
Returned Check Fee: Our office charges a $30 fee for any check returned for any reason.	

Person responsible for payment: _____ Relationship to Client:_____

Signature: _____

Telephone number: _____

Fee: $_____

Please Read Carefully

To avoid a conflict of interest, Bijal Patel LLC, who treats minors or adults involved in custody or visitation actions, may not perform any type of evaluations, forensic or otherwise, concerning custody, residence or visitation of the minor.

In addition, Bijal Patel LLC may not participate in any way with regard to any legal actions that her client(s), individuals, couples, and/or families may be involved in.

To participate in such action would undermine and/or damage her therapeutic efforts.

I (we) have read and understand the terms of the document.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Acknowledgement

I (we) request that Bijal Patel LLC provide counseling services to me (us). I (we) understand that I (we) am free to refuse this service, and that no guarantee has been made to me (us) as to the results I (we) will obtain from this service. I (we) accept responsibility for all charges for services rendered by Bijal Patel LLC. I (we) agree to the 24-hour cancellation policy, and I (we) understand that I (we) will be charged by Established Fee for appointments not cancelled at least 24 hours in advance.

Client Name _____ Date _____

Signature _____

Client Name _____ Date _____

Signature _____

Client Name _____ Date _____

Signature _____

Client Name _____ Date _____

Signature _____

Client Name _____ Date _____

Signature _____

Client Name _____ Date _____

Signature _____