WELL AND GOOD COUNSELING

WELL AND GOOD COUNSELING LLC

501 Corporate Drive West, Langhorne, PA 19047

— NEW CLIENT REGISTRATION —

Fields marked * are required. This form will be completed electronically through SimplePractice and signed digitally.

1. Client Information

Client full name *	Today's date *

Home address *

City *	State *	Zip code *

Email address *	Date of birth *

Gender *	Pronouns *	

Cell phone *	Home phone

Spouse / Partner (if applicable) *	

School name (if client is a student) *	Grade level *

2. Medical and Clinical Information

Family physician *		Psychiatrist (if applicable) *
_____		_____

Current medications and dosages * *List all, or write 'None'*

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3. Emergency Contact

Emergency contact name *		Emergency contact phone number *
_____		_____

4. Referral and Preferences

How did you hear about Well and Good Counseling? *

□ Psychology Today □ Google / Web search □ Referral from provider □ Friend / Family □ Other: _____

Would you like to receive text reminders for your appointments? *

□ Yes □ No

5. Clinical Intake

Your answers help your clinician prepare for your first session. There are no right or wrong answers.

What brings you to counseling at this time? *

What are your goals for counseling? *

Have you seen a mental health professional before? *

□ Yes □ No

If yes, when and what type of provider? *

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6. Financial Agreement

I have agreed to pay privately for mental health **counseling services** provided by Well and Good Counseling LLC. The agreed-upon fee is **$160** per session. The initial intake session is 60 minutes. All subsequent sessions are 50 minutes for adults and 45 minutes for children and adolescents, unless another arrangement is made. Shortened sessions will still incur the full fee due to required time blocks. Testing, paperwork, and other requests are billed separately according to the current Fee Schedule, available upon request. Payment is due at the time of service.

I acknowledge that Well and Good Counseling LLC will not bill my insurance company directly, but will provide me with a **superbill upon request.** I understand that my insurance company may or may not reimburse me for services provided by Well and Good Counseling LLC, and that no guarantee of reimbursement is made.

7. Cancellation Policy

Appointments must be cancelled or rescheduled at least **24 hours in advance.** No-shows and same-day cancellations will be charged the full session fee. Repeated late cancellations may result in a review of continued services.

8. Minor Client Authorization

Complete this section only if the client is under 18 years of age.

I, _____, am the legal parent or guardian of _____.

I authorize the above-named minor to receive mental health counseling services at Well and Good Counseling LLC. I confirm that I have full legal authority to consent to mental health treatment for this child, and that no court order limits my authority to do so. I understand I may revoke this consent at any time in writing.

Parent / Guardian signature *		Date *
_____		_____

Parent / Guardian printed name *		Relationship to client *
_____		_____

Client Agreement and Signature

By signing below, I confirm that I have read and understood this registration form, the Financial Agreement, and the Cancellation Policy. I agree to the terms described above and authorize Well and Good Counseling LLC to provide counseling services.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____

Client / Guardian Signature

_____

Printed Name

_____

Date