REMI FREEMAN, LCSW

Registration Form

Client name:____Today's Date: _______________

Home Address: __________________________________ City: ______________ State: ____ Zip:______

Email Address: ____

Date of Birth: _______________ Sex: M F Home Phone: ________________Cell: _________________

Client's Spouse/Partner (If applicable): ____

(If Client is a Student) Name of School & District: _____________________________ Grade: _______

Family Physician: ____ Phone: _______________________

Psychiatrist (if applicable) _______________________________Phone: _____________________

Emergency Contact: _____________________________________ Relation to Client: ________________

Emergency Contact's Phone number: ____

Is it alright to leave a VM or text on the cell number you provided? Y _____ N _____

Financial Agreement

I have agreed to pay privately for outpatient therapy services. The agreed upon charge is **$140** per 45 minute session which is to be paid at the time of service. I understand that Remi Freeman, LCSW does not accept any insurance plan and will never bill my insurance company directly, but will provide me with a receipt for services rendered. It is solely my responsibility to contact my insurance company to see if I may be eligible for any out-of-network benefits. Additionally, I acknowledge that there is a 24 hour cancellation policy which requires that I provide 24 hours when cancelling an appointment. Same day cancellations or appointments in which I do not show for scheduled sessions will be charged the full fee.

Signature: ____ Date: ________________

Treatment of a Minor

As the parent/guardian of __________________________, I authorize outpatient therapy treatment by Remi Freeman, LCSW. Please note that confidentially rules still apply.

Parent/Guardian Signature: ____________________________________Date: ________________

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