



Through The Fire REGISTRATION

GENERAL INFORMATION

Today's Date: ____ / ____ / ____

Client #1:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone/cell: _____ Okay to text? Yes No
 Email: _____
 Emergency contact: _____ Contact's phone: _____
 Emergency contact's relationship to you: _____

Client #2:

Name: _____
 Address: *(if different from above)* _____
 City: _____ State: _____ Zip: _____
 Phone/cell: _____ Okay to text? Yes No
 Email: _____
 Emergency contact: _____ Contact's phone: _____
 Emergency contact's relationship to you: _____

Whom may we thank for referring you? _____

FAMILY & RELATIONSHIP INFORMATION

Present Relationship Status (check all that apply):

- Married (yrs:____ mos:____)
- Partnered (yrs:____mos:____)
- In a new relationship (6 mos or less)
- Other: _____

If married, partnered or in a primary relationship, do you live with your significant other? Yes No

Others living in your household:

Name	Relationship	Age

MEDICAL INFORMATION

Client #1:

Primary Therapist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Other Specialist: _____ Phone: _____

Are you in recovery for addiction or compulsion? Yes No What program(s)? _____

Are you currently sober? Yes No

List any medications you are currently taking (including non-prescription or herbal remedies): _____

Describe any current physical and/or psychiatric concerns that you have: _____

Client #2:

Primary Therapist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Other Specialist: _____ Phone: _____

Are you in recovery for addiction or compulsion? Yes No What program(s)? _____

Are you currently sober? Yes No

List any medications you are currently taking (including non-prescription or herbal remedies): _____

Describe any current physical and/or psychiatric concerns that you have: _____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you agree to participate in the weekend workshop “Through The Fire: A Relationship Building Workshop for Couples Healing from Betrayal” and that you give permission to the clinical staff to provide psychoeducation and psychotherapy services. This includes the following clinician staff: Aaron Alan, MFT, CSAT and Nicole Ashton, MFT, CSAT. Psychotherapist interns may be attending and observing; interns are also bound by the limits of confidentiality.

CLINICAL ORGANIZATION

The clinical staff work as a treatment team and consult together and you authorize the exchange of information between clinicians in order to provide the most effective treatment.

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party. There are certain exceptions to this:

- When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.
- When a client threatens violence to an identifiable victim.
- When a client presents a danger of violence to others.
- When a client is likely to harm him/herself unless protective measures are taken.

Disclosure may also be required in certain legal proceedings. *If you have concerns about the content of sessions and any legal proceedings in which you are involved or expect to be involved (e.g., divorce, child custody cases), please let your therapist know.*

Before such disclosure is made, every reasonable effort will be made to appropriately resolve these issues or to notify clients.

ALL clients shall maintain the confidentiality of other participants and are not permitted to disclose any personal and/or identifying information about any other participant. This boundary is critical for client safety.

CONTACTING THERAPISTS

Clients may email, text or leave a voicemail for therapists at any time. Please be aware that therapists may not be able to immediately retrieve messages. **If you have a life-threatening emergency, dial 911.**

FEES, BILLING & PAYMENTS

Fees for the workshop are paid in advance, unless other arrangements have been made. The fee for the entire workshop is \$1500. There are no additional costs and the fee includes all aspects of the program; additional services, if rendered, may be billed separately (e.g. couples sessions, etc.).

If document preparation is required (e.g. legal proceedings, insurance appeals), clinicians reserve the right to bill for services, plus fees for materials (copies, outside services, etc.).

In order to prevent any misunderstandings about payment for services, please be advised of the following:

- (1) All services provided are billed directly to the client unless other arrangements have been made;
- (2) Clients are personally responsible for payment via credit card, cash, check or money order;
- (3) Statements can be provided for you to submit for insurance reimbursement;
- (4) You are responsible for submitting all claims to your insurance provider;
- (5) If payment is not received when services are rendered, payment may be applied to the credit/debit card on file if no other payment arrangements have been made.
- (6) If your credit/debit card is invalid and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

Payment Guarantee: clients are responsible for all incurred charges, even if you direct us to bill another person or third party. If you direct charges to be billed to another person or third party, you represent that you are authorized to give such direction. If you have directed charges to be billed to another person or third party who fails to make payment, you will be responsible for payment.

CREDIT CARD AUTHORIZATION

Credit Card Authorization: I authorize the maintenance of valid credit card information to guarantee my chosen payment option. Charges will appear on your credit card statement as "Aaron Alan, Inc."

Cardholder Name: _____	
Billing Address: _____	
City: _____	Zip: _____
<i>Circle Card Type:</i> Visa MC Discover AmEx	
Credit Card # _____	Expiration date: ____ / ____ / ____
	3 digit CVV code: _____
Cardholder/Client Signature: _____	Date: ____ / ____ / ____

The fee for the workshop is \$1800. Payment is due prior to the first day of the workshop. Your credit card will be charged the full amount of the workshop upon registration. A statement can be provided upon request. Clients are responsible for submitting all claims to their insurance provider.

I have read, understand and agree to the authorization stated above

Client #1:
Signature: _____ Date: _____
Printed Name: _____

Client #2:
Signature: _____ Date: _____
Printed Name: _____