Garet Bedrosian, LCSW, CIRT, CBT, CET
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Client Information
(Please Print Clearly)

Client Name _______________ SS# _______________ DOB _______________

Age ______ Birthplace _______________ Sex ______ Status (Circle) S M DP D W

Address _______________ City ________ State ______ Zip ______

Home Phone _______________ Cell Phone _______________ Work Phone _______________

Email _______________

Occupation _______________ Employer _______________

Parent/Spouse/Partner Name _______________ Employer _______________ Phone _______________

Referred By _______________ Phone _______________ May I Thank Them? _______________

Name of Responsible Party if Not Client _______________ Cell Phone _______________ Work Phone _______________

Address _______________ City ________ State ______ Zip ______

Employer _______________ Phone _______________ Ext ______

Occupation _______________ SS# _______________ DOB _______________

Fee Structure: Please speak with Garet about fees.

Please pay fees and discuss scheduling or other business related issues at the beginning of each session so the remaining time can be used for your growth and healing.

Authorization to Treat: I authorize and direct Margaret "Garet" Bedrosian, LCSW, CIRT, CBT, CET to perform such therapeutic procedures that her professional judgment may indicate to be advisable for the well being of myself, my child and/or my family. I understand that no warranty or guarantee is made as to the results of this treatment.

I also understand that insurance companies do not pay for missed appointments, and I agree to assume financial responsibility for the session fee charged for a failed appointment cancelled with less than 24 hours notice. Please sign below if you agree to the stated terms.

Signature_______________________________________**Date**_______________________

If you plan to submit claims for insurance reimbursement: Please remember that insurance is considered a method of reimbursing the patient for fees paid to the practitioner and is not a substitute for payment. Some companies pay fixed allowances others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. If this account is assigned to an attorney for suit or collection agency for collection of an unpaid balance, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of client medical record.

Signature_______________________________________**Date**_______________________