SAGEMONT COUNSELING CENTER

NEW CLIENT INFORMATION

PLEASE PRINT CLEARLY

Date _____

Client's First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home # _____ Work # _____

Cell # _____ Date of Birth _____

Email address _____ Sagemont Member? ◯ Yes ◯ No
PLEASE PRINT

PARENT'S INFORMATION *(if Client is a child/minor)*

First Name _____ Last Name _____

Home # _____ Work # _____

Cell # _____

By signing this form you authorize us to send you appointment reminders by email, text or phone.

The time scheduled for your session is reserved for you. If you are late for a session, we will use the time remaining, but you will be charged the full rate.

NO SHOW/CANCELLATION POLICY

THE INFORMATION BELOW MUST BE PROVIDED

If you miss an appointment without a 24-hour notice, you will be charged a fee of $40.00.
You are asked to leave a signed check (**with no date**), payable to Sagemont, to cover this fee or we will charge your credit card listed below.

CREDIT CARD INFORMATION

Type of Card ◯ MasterCard ◯ Visa ◯ Discover ◯ American Express

Credit Card # _____ Expiration _____ Security code _____

Name as it appears on your card _____

I authorize Sagemont Counseling Center to use the credit card listed above to pay any No Show/Late Cancellation fees or outstanding charges on my account.

Signature _____ Date _____