



NEW CLIENT INFORMATION

Date: _____

PLEASE PRINT CLEARLY

Client's First Name: _____

Last Name: _____

Address: _____

City/State: _____

Zip Code: _____

Home #: _____

Work #: _____

Cell #: _____

Date of Birth: _____

Sagemont Member? YES NO

Email address: (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 (We do **NOT** accept AMERICAN EXPRESS)

Credit Card Number: _____ Expiration Date: _____

Security code 3 digit on back _____

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: _____