

Kristen Eldridge, MEd, MC
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Client Information

Client Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone number: _____ Email: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Fee Agreement: Initial Assessment—\$150.00, Follow-up 50-minute Sessions—\$125.00 each.

I authorize the following credit card to be on file to charge the above stated rate for appointment fees and/or co-pays. In the event of decline of payment by credit/debit card during processing, a service fee of \$35 will be assessed in addition to resubmission of payment via alternate credit/debit card or other payment option. Your signature below indicates agreement of these terms including payment method and mutually agreed upon charges.

I authorize the following credit card to be on file and for Kris Eldridge, LPC to charge this credit card for counseling fees and/or co-pays.

Signature: _____ Date: _____

Type of card: _____ VISA _____ MasterCard

Name as it appears on the card: _____

Credit card number: _____

Expiration Date: _____ CVC Code (3-digit code on back of card): _____

Insurance: _____

Member ID#: _____ Group ID#: _____

Primary Insured's Name: _____ DOB: _____