New Client Paperwork

Clients Name: _____Date of Birth: _____ Age: _____

Client's SS#: _____Insurance Company: _____ID#: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

Married___ Divorced ___ Single___ Remarried___ Other_____

Address: _____City, State, Zip: _____

Cell Phone: _____ Work/Home Phone: _____

Employer: _____Position: _____

Referred By: _____

Previous Counseling: ___No ___Yes Clinician's Name: _____

Issues Addressed: _____

Spouse's Name: _____ Cell Phone: _____

Spouse's Address: _____ City, State, Zip: _____

Children (Names and Ages): _____

_____

Please list any physical health symptoms or problems you are having:

___Tired ___Sleep Issues ___Weight Changes ___School/Work Problems ___Loss of Interest

___ Excess Worry ___Self-Injury ___Substance use/Abuse ___Alcohol ___Drugs ___Addictions ___Hopelessness

___Anxiety ___Anger ___Tearful ___Panic/Anxiety ___Suicidal Thoughts ___ Indecisive ___Fearful

Other:_____

_____

Current Medications: Strength How Often Prescribed By Date

_____

_____

Past Medications (If applicable):

_____

Family History: ___Physical Abuse ___Sexual Abuse ___Domestic Violence ___Rape ___Arrests ___Hospitalization

The main issues in my life right now are:

1._____ 2._____ 3._____ 4._____

FOR MINOR CLIENTS:

Parent/Guardian Name: _____

Mother's Information:

Address: _____

City, State, Zip: _____

Cell Phone: _____ Work Phone: _____

Father's information:

Address: _____
City, State, Zip: _____

Cell Phone: _____ Work Phone: _____

Contact in case of Emergency:
Name: _____

Address: _____

City, State, Zip:_____ Cell Phone:_____

Home/Work Phone: _____

Patient Communication Preferences:
Our office will need to contact you to schedule and/or reschedule appointments, to schedule follow-up visits and other such administrative issues. To ensure that your privacy is maintained to the fullest extent possible, please select the method by which our office can contact you.

Cell Phone Calls & Text: _____

Leave Message? ___Yes ___No

Personal email: _____

Home Phone: _____

Leave Message? ___Yes ___No

Work phone: _____

Leave Message? ___Yes ___No

By signing below you agree that you have been given the opportunity to obtain a copy of the HIPAA Notice and that it is your responsibility to ask any necessary questions. In addition, by signing below you also agree to abide by the terms of the treatment agreement and consent to treatment for yourself or your minor.

Signature _____ **Date** _____

_____

Printed Name

Counseling Services of Atlanta, LLC

FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT

For and in consideration of services rendered and to be rendered to _____, I will promise to pay Counseling Services of Atlanta, LLC. I understand that the total charges are due when services are rendered.

For and in consideration of court attendance, I will promise to pay Counseling Services of Atlanta, LLC. I understand that Counseling Services of Atlanta, LLC bills at the rate of $200.00 per hour for court attendance. I agree to provide Counseling Services of Atlanta, LLC with my credit card information. I understand that the hourly rate begins when the therapist leaves the office location. I understand that a fee for two hours will be paid prior to court attendance, ($400.00) and is non-refundable if less time is needed. If the court attendance exceeds two hours, I understand that my credit card will be billed for the remaining time. In addition, I understand that I am not paying for the therapist testimony; I am paying for their time. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not. _____ (initial)

I understand that my credit card will be charged for any time that my therapist has to spend dealing with legal issues (responding to subpoenas/ court orders, phone conversations, letter writing, etc.). I understand I hold COMPLETE financial responsibility for any legal fees that my therapist incurs due to myself or my **MINOR** child (even if I am not the one making the request). I understand that ALL fees will be paid prior to my therapist responding to any legal issue and that I am paying for my therapist TIME and not RESPONSE. I understand that my credit Card will be charged a minimum of $50.00 for any communications and any time that exceeds 30 minutes will be charged an additional $50.00 _____(initial)

I understand that I am financially responsible for missed appointments, in which I do not give a 24-hour notice. Notice must be given via phone call. The fee for a missed visit (in which less then 24-hour notice is not given) is $75.00. This fee will be expected upon arrival of your next visit or charges to the credit card on file, before services are rendered. _____(Must initial)

I understand that I am financially responsible for all charges at the time services are rendered. I understand if I do not pay the entire amount due to Counseling Services of Atlanta, I hereby agree and give my permission to Counseling Services of Atlanta, LLC, to seek legal action to receive payment for services rendered and or work with CSA's collection agency to resolve payment. I understand that I will be responsible for paying the collection and/or legal fees should my account be turned over to collections. I also agree that in the event it is necessary to retain an attorney to enforce the terms of this agreement, relative to payment of fees, Counseling Services of Atlanta shall be entitled to reasonable attorney fees and cost of collection._____(initial)

Please provide us with your credit card information. The card will ONLY be charged if less than 24 hr notice is given to cancel an appointment or on accounts in which insurance did not pay or a balance is due.

Type of Card (Only Accept Visa & MC): Mastercard Zipcode:

Name as it appears on card: Expiration:

Card#: 3 Digit Security Code:

By signing below I am agreeing to the terms and conditions of this financial contract.

_____ _____

Signature Date