NEW CLIENT INFORMATION

Joanna Colrain, M.Ed, LPC, CGP
150 E. Ponce de Leon Ave., Suite 350, Decatur, GA 30030
770-220-4059

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Today's Date ____________________ (**Couples**, please complete 2 separate forms.)

Name of Client ____

Date of birth__________________________ SS #______________________________

Current address____

____

____

Home phone__________________ Work phone____________________ Cell Phone __________________

Email address ____

Occupation____

Employer____

Employer's address____

____

What is your reason for seeking therapy or consultation? ______________________________

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Have you consulted a mental health professional in the past? ______________________________

If so, when? ____

Are you presently under a physician's care? __________If yes, please, list conditions:__________________

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Do you take any medications regularly? ________If yes, please list them: ____________________________

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Please continue on next page.

In case of emergency, name of a local relative or friend to contact:

(This does NOT authorize me to release any information about your therapy.)

Name____Relationship____________________________

Phones: ____

Were you referred for services? By whom? ____

____

FINANCIAL POLICY INFORMATION:

Full payment is expected at the time services are rendered. Any other arrangements for payment are to be discussed with Ms. Colrain.

Your bill contains all the information necessary to file insurance claims. All insurance reimbursements should be made payable **to you**, the client, and **not to your therapist**. If you (or your insurance company) have any further questions, Ms. Colrain will be happy to assist.

Joanna Colrain does not accept HMO or managed-care insurance. She will be glad to provide you with information and a referral if you have this type of insurance. Or she will discuss the possibility of "going outside of your network." If you are unsure of your insurance coverage, please inform Ms. Colrain so that she may discuss it with you.

Appointment cancellations must be made at least **24 hours in advance** in order to avoid being charged the full fee.

Who is responsible for payment?

Name____

Address (if different than page one)____

____Phone______________________

I have read and understand the above policy and agree to pay for services provided.

_______________________________________ ____________________

Signature Date

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Health Insurance Portability and Accountability Act (HIPAA)
PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS CLIENT SERVICES AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA INFORMATION DESCRIBED ABOVE.

HIPAA INFORMATION RECEIVED:

____ ______________________
Signature Date

CLIENT SERVICES AGREEMENT READ & UNDERSTOOD:

____ ______________________
Signature Date

____
Please print name