

Heart to Heart Counseling Services, LLC

1585 Old Norcross Road, Ste 201

Lawrenceville, GA 30046

Phone: 404-275-6646

PATIENT INFORMATION

Section 1

Date: _____

Client's Name: Last _____ First _____ M.I. _____

Client's Date of Birth: ____/____/____ Sex: M _____ F _____ Client's SSN: _____ - _____ - _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home (____) _____ - _____ (can therapist leave a message on your home phone Yes ___ No ___)

Cell (____) _____ - _____ (can therapist leave a message on your cell or a text message Yes ___ No ___.)

Work (____) _____ - _____ (can therapist leave a message on your work phone Yes ___ No ___).

E-mail: _____ Employer/School: _____

RESPONSIBLE PARTY INFORMATION

If client is not a minor:

Client (if applicable, please sign name): I am not a minor, and I'm solely the responsible party for any and all services (but not limited to payment, submitting updated and accurate insurance information, etc) that I receive under Heart to Heart Counseling Services, LLC: _____ (Client Signature) Date: _____

If client is a minor:

Legal Guardian or other responsible individual: I am the legal guardian (or other responsible individual) of the client, and I'm solely the responsible party for any and all services (but not limited to payment, submitting updated and accurate insurance information, etc) that I receive under Heart to Heart Counseling Services, LLC: _____ (Legal Guardian or other responsible individual's Signature) Date: _____

By signing this form, I agree that my minor (child) or child in my care will receive services under Heart to Heart Counseling Services, LLC.

Legal Guardian (or other responsible individual's) Name:

_____ Date of Birth: ____/____/____

Relationship to Patient: _____ Party's SSN: _____ - _____ - _____

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Same address as the patient Different address than the patient (*please complete below*)

Home Address: _____

Same phone as the patient Different phone than the patient (*please complete below*)

Phone: Home (____)____ - _____ Work (____)____ - _____ Cell (____)____ - _____

INSURANCE & REFERRAL INFORMATION (please provide insurance card)

Section 3

Client, Legal Guardian, or other responsible individual: If not using insurance, please check preferred form of payment: CASH CHECK VISA MASTERCARD

Primary Insurance

Policyholder's Name: _____ Policyholder's SSN: _____ - _____ - _____

Date of Birth: ____/____/____ Insurance Carrier: _____

Policy/Group# _____ Insured's Employer: _____

Co-Pay: \$ _____ Deductible: Yes No Amount: \$ _____

Who referred you? _____ Have you sought therapy before? Yes No

Secondary Insurance

Policyholder's Name: _____ Policyholder's SSN: _____ - _____ - _____

Date of Birth: ____/____/____ Insurance Carrier: _____

Policy/Group# _____ Insured's Employer: _____

Co-Pay: \$ _____ Deductible: Yes No Amount: \$ _____

I agree to allow Heart to Heart Counseling Services, LLC to bill the above insurance company(s) for any and all services rendered under Heart to Heart Counseling Services, LLC. (Client, Legal Guardian, or other responsible party's signature) _____ Date: _____