

Paul Carroll, LPC, NCC

Effective and Healing Therapy

*Marriage, Family, and Individual
Counseling*

2550 Hamilton Mill Road, Suite 13, Buford, GA 30519
(770) 597-5805 LPC 002933 NCC 46874

Client Name(s): _____ DOB: _____

Responsible Party (if client is a minor): _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Phone Numbers Cell/Home: _____ Work: _____

Medications: _____ Dosage: _____ Physician: _____ Phone: _____

Insurance Company: _____ Tel# _____

Claim Address: _____ City: _____ Zip: _____

ID# _____ Group # _____

Primary Policy Holder _____ DOB: _____ Employer: _____

Client's Relationship to Insured: _____ Secondary Insurance: _____

Payment Information: The fee for the initial evaluation is \$120. Subsequent 45 minute sessions are \$100. Additional time will be billed in ! session increments at \$50. If a check is returned, there will be a \$30 fee.

Confidentiality: Confidentiality will be protected unless the client gives Paul Carroll specific written authorization to share information with another person or agency. However, current law requires counselors to inform appropriate persons/authorities if (a) there appears to be evidence of child abuse, or (b) there is reason to believe the client may be in danger of doing serious harm to self or others.

Cancellation of Appointments: Except in emergency situations, 24 hour notice is required for cancellation or rescheduling of appointments. If 24 hour notice is not given, the client will be responsible for payment of the scheduled session. Often insurance will not cover these expenses.

I have read and agree to the above. I assign directly to Paul Carroll, LPC all medical benefits, if any payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Paul Carroll to release all information necessary to secure the payment of benefits.

Signature

Date