6782 Jamestown Dr., Alpharetta, GA 30005
1730 Mount Vernon Road. Suite G, Atlanta, GA 30338
PH: 770-815-6853

Admitting Form

Date: __________________

Name: ________________________________ Date of Birth: ______________________________

Preferred Pronouns: ________________________________

Address:____

City: ____ Zip: _______________________

Home Phone: ______________________________________ Cell Phone: ___________________

Work phone: _______________________________________

Can we leave messages at this number?: __________________

E-mail Address: ____

Employer/School:____

Marital Status: ______________________ Spouse/Parent's Name:________________________

Person to Contact in Case of Emergency:____

Phone Number for Emergency Contact:____

How were you referred to our office?:____

Person responsible for billing if different than above:

Name: _______________________________________Relationship: _______________________

Address: ____

Home Phone: _______________________________ Work Phone:__________________________

ASC has a 48 hour cancellation policy. Regardless of the reason, any appointments that are not canceled at least 48 hours in advance of the appointment time will be billed at the rate of the full fee. Cancellations may be made by voicemail at (770) 815-6853.

Patient/Guardian 1 Signature: ____________________________________Date: ______________

Guardian 2 Signature: ____ Date:______________

ASC Consent Form

I, ____ , hereby grant permission to ASC to provide any therapy, testing, or diagnostic evaluation that may be deemed pertinent in the treatment of myself, my marriage, or my family (including my minor children). I willingly and voluntarily agree to mental health treatment and release any and all other providers and support/clerical contractors from liability claims. I understand that all fees are due at the time of service. In other words, the full fee must be paid at the end of each session.

I understand that there will be a $25.00 service charge for all returned checks and that all additional collection expenses are my financial responsibility if the amount of the returned check plus $25.00 is not paid in cash within 30 days. Outstanding accounts will be forwarded to our collection agency. I realize that my insurance policy is an agreement between me and my insurance company – not ASC.

Confidentiality

ASC's confidentiality policy is highly regarded and followed. All communications between client and therapist are kept strictly confidential. ASC will respond to any request for release of information regarding all our clients by indicating that a signed written release must be obtained prior to any information being released or discussed. Otherwise we will not even acknowledge that the undersigned is a client of ASC. Exceptions to this rule are where state law requires the reporting of threats of violence, harm, or child/elder abuse and neglect (from evidence or suspicion), and when information is subpoenaed by the courts.

Waiver of Legal Testimony

If your goal in entering counseling is to find someone to be your advocate in a legal situation, please let your therapist know. They will assist you with an appropriate referral. ASC is asking for your agreement at this time to never request a subpoena for any partner, contractor or employee of ASC or for any therapy records for the purpose of legal proceedings other than dates of treatment, a five Axis diagnosis, a synopsis of therapy goals and an evaluation of your general progress. Therapists will not go to court and prefer not to speak with your lawyer. If a subpoena is deemed necessary. The therapist will be forced to terminate the relationship due to the ethical conflict created with dual roles. In the event of a court appearance, the client will pay a $3,000 retainer ten days before the court appearance and the hourly rate for their time in court. By signing this form you are stating that you understand and accept these conditions of treatment.

Emergency Services

In the event that I become ill or I am injured while on the premises, I authorize ASC to provide or obtain emergency medical services (i.e. call an ambulance).

Consent Form of Financial Responsibilities & Communication Consent

Are you currently insured by Medicare?

☐ Yes

☐ No

Credit Card on File:
Your credit card will be charged for the following services:
1. All missed appointment fees (regardless of the reason for cancellation).
2. Paperwork and Form completions.
3. Services not paid for at the time of the appointment.
4. Phone calls of a clinical nature exceeding 10 minutes or frequently placed phone calls or e-mail exchanges will be charged at our normal rate.

Signature consenting to the payment of all charges:

____

Date of above signature:

____

Print name:

____

My signature acknowledges agreement to conditions as a patient/guardian of ASC set forth above.
*Medical decision documentation must be provided without two signatures.

Patient/Parent/Guardian Signature: ____

Date of signature:____________________________

Print name:____

Parent/Guardian 2 Signature: ____

Date of signature:_____________________________

Print name: ____

Communication Addendum to the Informed Consent Agreement

Secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact ACSC will be considered to imply consent to return messages to clients via the same non-secure technology, pending further clarification from client. Please check the area below which modes of communication are permitted and which are not permitted. This consent may be altered at any time should circumstances or preferences change. In the event that client chooses not to allow non-secure modes of communication, contact will only be made via wire to wire phone, wire to wire fax, or mail.

Consent to Voice, Text, E-Mail, and Fax communication TO & FROM client's cell/smart phone, non-secure email, fax or e-fax:

Scheduling Appointments:	Permitted ________	Not Permitted _______
Appointment Reminders:	Permitted ________	Not Permitted _______
Between Session Contact:	Permitted ________	Not Permitted _______

Statement of Validation

I have read this Statement of Services, it has been adequately explained to me, and I understand its contents.

Print name:____

Signature and Date:____