



2004 Cliff Valley Way NE
Atlanta Georgia 30329

New Patient Information

Please Print (If the patient is a child, please use his/her name)

Today's date: _____ DOB: _____ Age: _____
Gender: ☐ F ☐ M Marital status: _____ SS#: _____ - _____ - _____
Last name: _____ First name: _____ MI: _____
Address: _____ City: _____
State: _____ Zip: _____ Tel: (home) _____ (work): _____
Email address: _____ Referred by: _____
Reason for today's visit: _____

Payment is required at the time of service.

Name of person responsible for payment: _____ Tel: _____

Our office does not file any insurance. We will provide you with the information necessary to file claims with your carrier. Outstanding balances that are not paid in full may be turned over to a collections agency.

Parent Information:

Mother: _____ DOB: _____ SS#: _____ - _____ - _____
Address: _____ City: _____
State: _____ Zip: _____ Tel: (home) _____ (work): _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____ Tel: _____

Father: _____ DOB: _____ SS#: _____ - _____ - _____
Address: _____ City: _____
State: _____ Zip: _____ Tel: (home) _____ (work): _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____ Tel: _____

Parents marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

If parents are divorced, what is the custody arrangement? Please provide a copy of relevant divorce papers.

Physical: _____ Legal: _____

List members of current family in order of birth:

Name	Gender	Age	Relationship	Occupation

Fee Information

Fees for outpatient psychotherapy are \$360.00 for a 60 minute session. Charges for longer or shorter sessions are prorated based on these charges.

Charges for a forensic evaluation (related to a legal case) are based on a rate of \$360.00 per hour. Court fees are at a rate of \$3,600.00 for a full day of court and \$1,800.00 for 1/2 day of court. Deposition fees are charged at \$450.00 per hour. Forensic evaluations are covered in a separate agreement.

Some psychological tests are billed on an individual basis at the time they are scored.

Please note that changes to the fees may occur at any time. However, fee changes will be posted in the office 30 days prior to the change.

Please read and sign

Charges for office visits must be paid at the conclusion of each visit.

Cash, Check, Visa and Master Card are accepted.

24 hour notice is required for cancellations of appointments. Failure to give this notice will result in a charge of the regular fee.

If it is necessary for this account to be assigned to a national collection agency for collections and/or lawsuit, the prevailing party shall be entitled to reasonable attorney's fees and/or costs of collections. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

Note: There is no video or audio recording permitted during the sessions at Cliff Valley Psychologists, unless prearranged by provider. **Initial** _____

Responsible party: _____ **Date:** _____

This form was completed by: _____

Relationship to patient: _____