Elaine Barron, L.M.S.W.
12700 Century Drive Suite E
Alpharetta GA 30009

CLIENT REGISTRATION

You have my permission to leave phone messages and send mail to:

Client Name:_____ Birthdate:_____ Age: _____
Address:_____
Street City State Zip_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____
Marital Status: _____ Social Security #: _____
Employer: _____
Referred By: _____

CLIENT GIVES PERMISSION FOR CONTACTING THE FOLLOWING PERSON IF IN THERAPISTS' JUDGMENT SUCH CONTACT IS CONSIDERED NECESSARY

_____

Name Relationship to Client Address Phone

RESPONSIBILITY FOR PAYMENT

In the event when you find it impossible to keep an appointment, please give us a call 24 hours in advance. Otherwise, your credit card will be charged for the amount of the appointment. If an emergency prevents you from keeping your appointment, just let us know and special arrangements can be made.

Elaine Barron Counseling maintains a timed appointment schedule and asks that you be here and ready for your appointment on time. If you know that you will be late, please call. We will make every effort to see you at a later time.

Thank you for your support and understanding. It is our pleasure to provide you with the very best of treatment and service.

AUTHORIZATION TO CHARGE CREDIT/DEBIT CARD

To be in compliance with the current privacy law, your credit card information will be protected.
I, _____, give permission to Jordan Stones Counseling Center/Mandi Peek, MS, LPC to charge my credit/debit card for any late cancellation and/or missed appointment fees incurred on my account. I understand that I am responsible for all charges.

Name of Card Holder:_____
Signature:_____
Date_____
Please Circle One: Visa MasterCard AMEX Other
Card Number: _____
Exp Date:_____
Security Code:_____

(Over for second side)

RESPONSIBILITY FOR PAYMENT CONTINUED

I understand that all services are rendered and charged to me and not to a third party or an insurance company. I understand that I am responsible for paying for all services and charges that are not covered or not authorized by an insurance company, including extended sessions, telephone calls, preparation of reports, and any unkept appointments. I understand that I am responsible for paying full charges on all appointments that are unkept, rescheduled, or cancelled with less that 24 hours advance notice to Jordan Stones Counseling.
I understand and agree that I will pay all fees at the time services are rendered or billed to me. I understand that Jordan Stones Counseling cannot accept responsibility for collecting or negotiating a settlement on a disputed claim. I hereby accept full and complete responsibility for all debts and obligations during the course of the above-named client's evaluation and/or treatment. For the purpose of collecting debts, I understand and agree that the above information will be released to Nations Recovery Center (NRC) or other collection agency in the event that I do not pay my account within thirty (30) days of services being rendered. I authorize all of the above information, including last date of service and total amount of debt, for the purpose of collecting the debt.

_____

Client's Signature Date