Road to Restoration Counseling Services
1300 Ridenour Blvd. Ste. 100
Kennesaw, GA. 30152
678-819-3794

Client Registration Information

Name _____ Date _____

DOB _____ Age _____ Sex _____

Address _____

City _____ State _____ Zip Code _____

Email: _____

Telephone: (Home) _____ Ok to leave message? Yes _____No _____

(Cell) _____ Ok to leave message? Yes _____No _____

(Work) _____ Ok to leave message? Yes _____No _____

Emergency Contact: _____ Phone Number: _____

Referred by: _____ May we thank them? Yes _____ No _____

Reason for visit _____

Please inform us of how you wish our office to communicate with you and in what form of communication.

By giving permission this is your agreement to allow non-secure cell phone calls and emails and/ or text messages with my therapist as noted below.

Please check the appropriate boxes:
For voice communication to and from client's cell/smart phone indicate below with the letter
For Email/Text communication to and from client's email indicate below with the letter

Cell Phone Voice Communications	Permitted	Not Permitted
Cell Phone & Text Messaging Scheduling appointments	Permitted	Not Permitted
Text Appointment reminders __	Permitted	Not Permitted
Between Session Contact	Permitted	Not Permitted

Guarantor Information (If different from patient)

Name: _____ DOB: _____ Relationship to Patient: _____

Address: _____

City _____ State _____ Zip Code _____

Email: _____

Telephone Number: _____Ok to leave message? Yes _____No _____

Acknowledgement of Financial Policy

I give permission for Gina Barthelemy-Morton and Road to Restoration Counseling Services, LLC. to send required information to my insurance company. I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. Payment is due in full at time of service. We reserve the right to cancel any appointment for failure to pay. Insurance copays, deductibles, and co-insurance amounts that we collect are based entirely on the information provided to us by your insurance company and are subject to change once the claims have been processed. We are happy to file claims on your behalf; however, you are responsible for providing us with your correct insurance information, including any changes in coverage after treatment begins. If a claim is denied because the information you provide is incorrect, you will be responsible for all unpaid charges on your account.

CANCELLATIONS — At least 24-hour notice is required to cancel an appointment. Late cancellations or no shows will be charged a full session fee of $150 instead of your regular copay or co-insurance amount, because we cannot bill your insurance company for missed appointments.

By signing below, you acknowledge that you have read and understand the above policy and that you have been given the opportunity to ask questions regarding the policy.

_____(Client Signature) _____(Date)