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: __________

Office: 404 728-0728
Fax: 404 634-7802
Email: cvp2@bellsouth.net
Website: cliffvalleypsych.com

List members of current family in order of birth:

Name	Gender	Age	DOB	Relationship	Occupation

Fee Information

Fees for outpatient psychotherapy are $390.00 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 $390.00 per hour. Court fees are at a rate of $4,000.00 for a full day of court. Deposition fees are charged at $500.00 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: ____