Atlanta Specialized Care

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:_____

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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

ASC considers all communication, either with you or with anyone the therapist speaks with for case coordination to be privileged information. Any trip to court or discussion with a lawyer can put the therapist in an extremely dangerous ethical and legal position. If your goal in entering counseling is to find someone to be your advocate in a legal situation, please let your therapist know and they will assist you to the best of their ability to find the right person to help with your legal testimony.

ASC will never release their individual therapy notes without a direct court order. ASC is asking for your agreement at this time that you will never request a subpoena for any partner or employee ASC or for any therapy records 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.

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).

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Consent Formof 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.

Communication 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

My signatureacknowledges agreement to payments of all charges, conditions as a patient/guardian of ASC set forth above, and communication consent.

*Medical decision documentation must be provided without two signatures.

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

Patient/Parent/Guardian Signature:_____

Date of Signature:_____

Print Name:_____

Parent/Guardian 2 Signature:_____

Date of Signature:_____

Print Name:_____