Hope Springs Counseling Center, LLC
127 ½ North Broad Street, Suite 3, Monroe, GA 30655
(404)784-6809

CLIENT INFORMATION FORM

Client Name: _____ Date: _____
First Middle Initial Last Jr/Sr/III

Street Address: _____ Home Phone: _____
City: _____ Work Phone: _____
State/ZIP: _____ Cell Phone: _____
E-Mail: _____ Fax: _____

Social Security Number: _____ DOB: _____ Age: _____

Work/School:

Occupation: _____ Employer/School: _____

If client is child/dependent, please complete the following:

Guardian Name: _____ Relationship: _____
(If Applicable) First Middle Initial Last Jr/Sr/III

Occupation: _____
Employer/School: _____

Social Security Number: _____ DOB: _____ Age: _____

Insurance:

Insurance Carrier _____ Subsciber Number _____
Subscriber Name _____ Group Number _____
Relationship to Subscriber if other than client _____

CANCELLATION AND UNKEPT APPOINTMENT CHARGES

To cancel and/or re-schedule your appointment, please call (404) 784-6809 at 24 hours in advance of your appointment time. This allows us adequate time to reach others who are want your appointment time or day.

Cancellations less than 24 hours in advance and "no shows" will be charged a fee of $65.

Please read the attached Information Disclosure Statement. If you have any questions, feel free to discuss them with your counselor.