Therapy with Dr. G.
1949 Seymour Dr NW ◆ Acworth, GA 30101
Phone 678-398-7224 ◆ Fax 844-398-7224
Email drg@therapywithdrg.com
Website www.therapywithdrg.com

INTAKE INFORMATION FORM

Client's Full Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number (this is needed for insurance purposes only): _____

Age: _____ Birthdate: _____ Email: _____

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Occupation: _____

Education Level: _____Religious Preference: _____

Who may we thank for referring you? _____

Primary Physician: _____ Phone/Fax Number: _____

Emergency Contact: _____ Relationship: _____ Ph#: _____

Describe any major health problems you have had. _____

_____

List any medications you take on a regular basis:

Name of Medication	Dose	How Often	Reason

Substance Use

	Yes	No	Which	How Much	How Often
Alcohol (beer, wine, liquor)					
Smoking (cigarettes, cigars)					
Recreational Drugs (e.g., Marijuana, Cocaine, Crack)					
Illicit Substances (e.g., huffing)					

Describe your reason for seeking help: _____
_____

What efforts have you made to handle the problem? _____
_____

Do you see any other person as being involved in your problem? No

If so, Who? _____ Relationship: _____

How? _____

To whom have you turned for help or support? _____

How were they of assistance? _____

Who suggested you seek help? Spouse/Significant Other

Have you received psychiatric or psychological help or counseling of any kind before? No

When? _____ Where? _____ With whom? _____

Have you ever had suicidal thoughts? No Have you ever attempted suicide? No

When? _____ If you attempted, how? _____

How were you rescued from your attempt? Self-Rescued

Use the drop-down menu to indicate which problem(s) pertain(s) to you: Fatigue/Headaches/Other Health Concerns

Please list any other problems not on the previous list: _____
_____

Please list members of your family and others in your home:

Name	Age	Relationship	Occupation

FOR COUPLES ONLY

Are you married? No Cohabitating? No Engaged? No

How long? _____ How long did you date before marriage/cohabitation/engagement? _____

What was it about your wife/partner that made you fall in love? _____
_____

What was it about your husband/partner that made you fall in love? _____
_____

What do you miss about your husband? _____
_____

What do you miss about your wife? _____
_____

What do you see as the main problem? Other Other: _____

What do you want to accomplish through counseling? _____
_____

If your marriage were ideal, what would it look like?

Husband/Partner 1	Wife/Partner 2

BILLING INFORMATION

Insurance Company: _____ Phone Number: _____

Claims Address: _____

Policy Number: _____ Group Number: _____

Authorization Code (if required): _____ Copay: _____

IF EAP:

EAP Company: _____ EAP Authorization # _____ No. of visits _____

AGREEMENT FOR THERAPY

Initial each statement below

Initial Here — Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, **cancellations must be made at least 24 hours in advance**. **Appointments cancelled with less than 24 hours' notice, or no-show appointments, will be billed the full private pay fee for the missed session.**

Initial Here — No additional appointments will be made after three consecutive no-shows or five consecutive late cancellations. **Appointments will be suspended, if your account reaches an unpaid balance of $150 or more, until the balance is paid.** We are willing, at any point, to give you a referral.

Initial Here — **Therapy sessions will be 45 minutes in length** unless otherwise agreed upon by you and your therapist.

Initial Here — Payment for services is due at the time they are rendered unless prior arrangements are agreed upon with your therapist. If you have insurance coverage that will apply to the cost of your therapy, your therapist will cooperate in providing any appropriate information and signatures required.

Initial Here — Hypnotherapy is generally not covered by insurance; therefore, you are responsible for payment in full. You may file with your insurance for reimbursement if you think they will cover the charge.

Initial Here — There is a **$45 fee for any returned checks**.

Initial Here — If we are unable to collect payment from you (or your insurance company), the bill will be forwarded to a collection agency.

By initialing each statement above, and signing this form, I acknowledge that I have read, understand, and will comply with the terms set forth in the Agreement for Therapy.

_____ _____

Signature Date