WALLIS AND ASSOCIATES PROFESSIONAL COUNSELING SERVICES, INC

131 Prominence Court, Suite 220, Dawsonville, GA 30534 Office: 706.490.9204
www.walliscounseling.org

CLIENT REGISTRATION FORM

Name: _____

Street Address: _____

City: _____ St: _____ Zip: _____

Home #: _____ Alternate #: _____

Date of Birth: _____/_____/_____Social Security No.: ____ -____-_____

Age: _____ Email:_____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other:

Responsible Party: _____Relationship: _____

Occupation: _____Work Telephone: _____

Employer_____ Address: _____

Spouse or Parent/Guardian: _____

Emergency Contact: _____ Relationship: _____

Phone Number_____

How were you referred to our office? _____

May We contact you Via:

Home Phone - Yes No

Work Phone - Yes No

Cell Phone - Yes No

E-mail - Yes No

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I authorize the release of medical information necessary to process any of my insurance claims if I choose to file insurance out of network. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged a $50.00 fee, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

Name: _____

Signature: _____ **Date:** _____