SANDY SPRINGS PSYCHOLOGICAL ASSOCIATES *Client Information Form*

Thank you for choosing Sandy Springs Psychological Associates. Please provide us with the following information:

Client Name:	C	Date of Birth://	
Street:	City:	State: ZIP:	
Cell Phone:	_ Alternate Phone:	🗆 Work 🗆 Other	
E-mail Address:			
Is it okay to send a rem	ninder text for upcoming appoi	ntments? (Circle One): YES / NO	
Preferred meth	od of Contact: (Circle One): C	ell Phone / Text / Email	
Responsible Party (if someone	other than the client – i.e. $ $	parent or guardian)	
Name:	Relationship to Client:		
Cell Phone:	Alternate Phone:	Work 🗆 Other	

All services rendered by Dr. Chuck Jenkins are charged to the client. Insurance may or may not pay for your counseling appointments, testing or assessment. Insurance reimbursement rates, deductibles (individual and family) and levels of authorized care often vary between plans and companies. <u>You, as the client or guardian</u>, <u>are responsible for all fees – regardless of insurance coverage</u>. The client or other responsible party is required to pay for services when rendered unless other arrangements have been made in advance. Your appointment time is for you only – this office does not double book counseling appointment times. As a result, we cannot fill that time without appropriate prior notice. Therefore, <u>all appointments must be cancelled at least 24 hours in advance to avoid being charged for that time</u>.

<u>Please be advised that if you are doing any testing with Dr. Jenkins and request a written report and/or</u> <u>letter, there will be a separate charge for this service.</u>

I, the undersigned, have read, understand and agree to the aforementioned responsibilities and fee requirements indicated.

Client Signature

Date

^{*} Your insurance coverage may accept claims from out-of-network providers. A copy of your superbill and receipt, or other documentation needed to file a claim, is available upon request – please see the Office Manager