Awareness Counseling Center
100 Katelyn Circle, Suite B
Warner Robins, GA 31088
www.awarenesscounselingcenter.com

Patient Information

Patient's Name: _____ SS#: _____ Sex: Male o Female o
Date of Birth: _____ Age: _____ Marital Status: Single o Married o Separated o Divorced o Widowed o
Home Address: _____City: _____ Zip: _____
Home Phone: (_____)_____ Cell Phone: (_____)_____
Is it ok to leave messages? Yes__ No__ Is it ok to leave messages? Yes__ No__
Email Address: _____ Occupation: _____
Employer (School, if student): _____ Work/School Phone: (____)_____
Address: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Number: (_____)_____

Responsible Party and/or Insurance Information

(This is the person/employee/parent that is primary policyholder.)

Name of Insured: _____ SS#: _____ Date of Birth: _____
Primary Insurance Company: _____
Policy/ID Number _____Group Number:_____
Employer: _____ Work Phone: (_____)_____
Secondary Insurance Company: _____
Name of Insured: _____ SS#: _____ Date of Birth: _____
Policy/ID Number_____ Group Number: _____
Employer: _____ Work Phone: (_____)_____

Insurance Billing: The therapists of Awareness provide insurance filing for their patients. **It is your responsibility to verify your benefits and know if your therapist is in network for your plan.** By signing this form you are agreeing to engage in our services, for us to file your insurance claims, and for us to submit the information to them that they need to know in order to process the claims. You are also agreeing that you understand that you are responsible for all fees regardless of whether your insurance covers the therapists services or not - including all deductibles and copayments. It should also be noted that we ***do not file secondary insurances***. If you would like to recoup your copay from your secondary policy, your therapist can provide a receipt for your payment. ***If your balance has not been paid after 90 days your therapist may utilize a collections agency to assist in collecting the amount due.***

Payment Policy: We require payment or co-payment for services ***at the time services are rendered***.
Payment may be made by cash, debit, or credit card (MasterCard/Visa/Discover/American Express) and we require that a credit card be kept on file for services. This policy is in keeping with industry standard practices in billing and insurance filing.

Self-Pay Policy: The self-pay fee for services at Awareness is $125 per session. This is the rate per session if you choose not to use your insurance, your insurance doesn't cover our services, or you do not have insurance.
The self-pay session fees are ***payable at the time services are rendered***.

Appointment Cancellation Policy: We require that cancellations for scheduled appointments be received 24 hours in advance. **Unkept appointments which are not properly cancelled are subject to an unkept appointment fee, which can be equal to but not exceed the therapist's regular appointment fee.** Multiple unkept appointments may result in being discharged from services at your individual therapists discretion. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge.

I have read and understand the above stated policies of the therapists at Awareness.

Signature of Responsible Party (required): _____

Date:_____