

Melodie Good, L.P.C.

4210 Columbia Road, Suite 4D Martinez, GA 30907
thetherapist@melodiegood.com
706-250-2030

Client Information

Name _____ D.O.B. _____

Parent/Guardian name if applicable _____

Address _____

Cell # _____ Home # _____ Work # _____

E mail Address _____

May I leave a phone message? _____ May I text you? _____

Preferred method of contact _____

Whom may I thank for referring you? _____

Emergency Contact Name _____ Phone _____

Please fill out the following only if you are using health insurance.

Insurance Plan _____ Subscriber _____

Relationship to client _____ Subscriber SS # _____ Subscriber DOB _____

Policy Number _____ Insurance Phone _____

Insurance Address _____

Fee Schedule

All therapy services are \$125.00 per 50 minute session. Other time increments are available. Payment is due at time of service.

Melodie Good, L.P.C.

24 Hour Appointment Cancellation Policy

If you fail to give a 24 hour notice of cancellation of your appointment, you will be charged the entire amount of your session. Exceptions will be made for emergency situations.

Signature _____ Date _____

Insurance Authorization

I authorize Melodie Good, L.P.C. the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to be paid to Melodie Good, L.P.C. for services provided. Your insurance policy is a contract between you and your insurance company. You are ultimately responsible for the payment of your sessions. Filing your insurance is a courtesy provided to you. You will be responsible for any balance that your insurance company has not paid in a timely manner.

Name _____ Signature _____ Date _____

Co-pays/Co-Insurance

Your co-pay, co-insurance, and/or deductible are due at the time of service.

Signature _____ Date _____

HIPPA

A copy of the Health Insurance Portability and Accountability Act of 1996, which protects your privacy rights as a patient, is available for you to read and review. A copy will be made available to you at your request.

Initial _____ Date _____

Consent to Treatment

I agree to give Melodie Good, L.P.C. consent to provide psychotherapy, counseling and/or assessment to _____. I understand that I may withdraw this consent at any time.

Signature of client or guardian _____ Date _____