MOVING FORWARD LIFE SERVICES, LLC Date: _________________

Last Name ____________________________First Name _____________________________ MI _________

Address ____

City ____________________________ ST __________________ Zip ______________________

Home Phone ____________________Work Phone ____________________ Cell Phone ________________

May we call you or leave a message for you at – Home ( ) Your Work ( ) Your Cell ( )

Birth Date ______________ Age ______ Email ____

Marital Status: S____ M ____ D ____ P ____ # of year's _____ Spouse/Partner's Name __________________

Race/ethnicity __________________________ Educational Level ___________________________________

Responsible Party: Name _________________________________ Relationship to Client ________________

Name of person to contact in the case of an emergency ____

Phone # ____

How did you hear about Moving Forward Life Services? ____

Employment Information

Employer ____

Address ____City _____________ ST______ Zip __________

Phone # ____ Employed: Full Time ( ) Part Time ( )

Length of time in current position _______________________________Current Job Title _________________

Do you enjoy your work? Yes ______ No ______

Can we send you information about Moving Forward Life Services through your email address ( ) Y ( ) N

FINANCIAL AGREEMENTS, POLICES, PROCEDURES AND CONSENTS

Fees

The fees for the initial sixty minutes session is $125.00, each additional fifty-minute session is $80.00, which is payable at the time of each appointment, unless other arrangements are made. You can make payment with cash, check, or credit/debit card.

Appointments, Cancellations and No-Shows

At the conclusion of your initial interview you and your counselor may agree to schedule for additional appointments. Because consistency is an important part of the counseling process, the appointment time you schedule is reserved for you and is not available to anyone else. If you are unable to keep a scheduled appointment, you must notify the Center at least **24 HOURS** in advance to avoid having to pay for the canceled or missed appointment. Insurance will not pay for missed appointments; therefore you are responsible to pay a minimum fee of **$40.00** as contracted with the Center.

INSURANCE INFPRMATION

Primary Insurance Insured is: Self _____ Spouse _____ Child _____ Other _____

Name/Date of Birth ____

Secondary Insurance Insured is: Self _____ Spouse _____ Child _____ Other _____

Name/Date Birth ____

MOVING FORWARD LIFE SERVICES, LLC Date: _________________

Insurance

Although you are ultimately responsible for your fee, health insurance may pay a portion of the charge. At your request the Center's office staff will contact your insurance company regarding the benefits for our services and will also file your claims.

If your annual deductible has been met it may be possible for you to pay only your portion of the fee and for the insurance company to pay the balance to the Center. If the deductible has not been met you will be responsible for paying the full fee until the deductible has been satisfied. Co-pays are due at the time of your session.

Signature ____ Date _______________________

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Phone: 770-939-5800 * Fax: 770-708-7933