

CARTER & EVANS
2111 W. SWANN AVENUE, SUITE 104
TAMPA, FLORIDA 33606
813-251-8484 AND 813-258-1272
E-mail: Tim@evanstherapy.com AND geri@cartertherapy.com

DATE: _____

NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____

RELATIONSHIP STATUS: **SINGLE** **MARRIED** **OTHER**

HOME ADDRESS: _____ **PHONE:** _____

CITY/STATE/ZIP CODE: _____ **CELL PHONE:** _____

SOCIAL SECURITY # _____ **EMAIL:** _____

EMPLOYER/COMPANY NAME: _____

ADDRESS: _____ **PHONE:** _____

FATHER'S OCCUPATION _____ **FATHER'S EDUCATION** _____

MOTHER'S OCCUPATION _____ **MOTHER'S EDUCATION** _____

FATHER'S VALUES _____ **MOTHER'S VALUES** _____

FAMILY CONSTELLATION: (BROTHERS & SISTERS)

TRAITS MOST DIFFERENT FROM YOU

NAME _____ **AGE** _____ _____

NAME _____ **AGE** _____ _____

NAME _____ **AGE** _____ _____

NAME _____ **AGE** _____ _____

NAME _____ **AGE** _____ _____

REFERRED BY _____

FAMILY PHYSICIAN _____ **PHONE** _____

EMERGENCY CONTACT _____ **PHONE** _____

REASON FOR COMING _____

CANCELLATION POLICY: To avoid a full service charge requires cancellation or changes **48** hours prior to scheduled appointment. **Hourly Fee** \$180.00 per hour therapy session and \$200.00 for Mediation services.

Client Financial Responsibility Acknowledgement

Client Name: _____

The undersigned hereby acknowledges that she/he has been informed that the following have not been approved for payment under the Client's mental health benefits program and that therefore the undersigned agrees that she/he, and not the insurance provider, will bear full financial responsibility for payment of all charges:

1. *Insurance:* It is the Client's responsibility for the payment of services provided. If your insurance does not provide coverage or payment for services rendered, it is the client's responsibility for payment of services. Furthermore, it is the client's responsibility for providing pre-authorization, co-payment, number of visits, and any other contact that is needed with your insurance company. If Carter and Evans are required to contact and work with your insurance provider, you may be billed for additional services and time.

_____ **Initials**

2. *Cancellation Policy:* To avoid a full service charge on any service, Carter and Evans require cancellations or changes 48 hours prior to scheduled appointments.

_____ **Initials**

3. *To guarantee your scheduled appointment,* cancellation policy, and to ensure required co-payments, deductibles, payment from your insurance, Carter and Evans requires a credit card number, expiration, and billing address.

_____ **Initials**

Credit Card Number:

Expiration Date:

(Visa or Master Card or Debit Card #)

mm/yy

Name on card (print)

Signature

Credit Card Billing Address:

Street Address

Apt #

City

State

Zip Code

4. *All payments* are due when service is rendered. Pre-payments for future services may also be requested at the sole discretion of Carter and Evans.

_____ **Initials**

**Signature of Client or
Client's Legal Representative**

Date