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____

____

<u>CANCELLATION POLICY</u>: To avoid a full service charge requires cancellation or changes **<u>48</u>** 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**