CAROLA HERTLE-JONES, LCSW, ACSW
3855 SHALLOWFORD ROAD, SUITE 420
MARIETTA, GEORGIA 30062
770.592.0566 FAX 770.993.8004

CLIENT INFORMATION FORM

Client's Full Name_____ Date_____

Address_____ City/State/Zip Code_____

Email Address_____ Home Phone #_____Cell Phone #_____

(Email is used only for administrative purposes. Email is not an encrypted means of communication. By providing me your email address, you are consenting to receive email.)

Age_____ Date of Birth_____ Sex_____ Marital Status: M__ S__ D__W__ Separated __

Referred By_____

Employer_____ Work Phone #_____

Employer's Address_____

School_____ Grade_____ Special Education_____

Spouse/Guardian Name_____ Date of Birth_____ Sex_____

Primary Doctor_____ Phone #_____

Primary Insurance Co._____ Phone #_____

Address to Mail Claims_____

Insured_____ Insured D.O.B._____ I.D. #_____ Group #_____

Secondary Insurance Co._____ Phone #_____

Address to Mail Claims_____

Insured_____ Insured D.O.B._____ I.D. #_____ Group #_____

I will be paying for my sessions by: CASH____ CHECK____ CREDIT CARD____

I understand that full charges will be made for appointments not cancelled at least 24 hours in advance.

I hereby authorize treatment by Carola Hertle-Jones, LCSW, ACSW on the above named client. I understand I am financially responsible for all services rendered including any changes or penalties made to Carola Hertle-Jones, LCSW, ACSW for any necessary outside collection assistance. I understand that Carola Hertle-Jones, LCSW, ACSW is not responsible for any final decisions of reduced or non-payment by my insurance company. I authorize the release of my information necessary to process claims and secure payment for service rendered.

Client/Guardian Signature _____