1 Alliance Counseling
& Psychotherapy Services

181 Tenth Street NE, Suite 103
Atlanta GA, 30309
Phone: 678-310-6631 Fax: 866-907-3948
info@1alliancecps.com

Client Information

Last Name: First: MI:

Birthday: Gender: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐ Never Married ☐ Separated ☐ Domestic Partnership ☐ Married ☐ Divorced ☐ Widowed

Street Address (No PO Boxes):

City: State: Zip Code:

Phone: Mobile: May we leave a message or SMS? ☐ Yes ☐ No

E-mail: May we e-mail you? ☐ Yes ☐ No

**E-Mail and SMS are not considered to be a confidential mediums of communication. Appointment reminders and non-sensitive correspondence may be sent to you via email or SMS. Other communication should be completed in person with your therapist.*

Please list any children:

Name: Age: Name: Age:

Name: Age: Name: Age:

Referred by:

Emergency Contact: Phone:

Relationship to Client:

Primary Insurance

Carrier: Policy / Group Number:

Insured's ID: Insured's Employer:

Insured's Name (if different from Client's): Insured's Birthday:

Insured's Address:

EAP Insurance Company:

EAP Authorization Number:

Authorized EAP Sessions:

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Secondary Insurance

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Insured's ID: Insured's Employer:

Insured's Name (if different from Client's): Insured's Birthday:

Insured's Address:

I request that payment of authorized third party benefits be made on my behalf to the appropriate therapist at 1 Alliance Counseling & Psychotherapy Services, LLC for any services furnished to me. I understand my signature also authorizes release of any information contained in my records to any relevant insurer, or its assignees, necessary to pay a particular claim. By my signature, I acknowledge that I am ultimately responsible for payment of all fees in the event that payment is not received by a third party for any reason.

Signature of Client or Responsible Party

Date