Positive Energy Solutions Corporation

2993 Piedmont Road NE
Atlanta, Georgia 30305

Client Information

Client's Name: _____ SS#_____ Gender: M F

Date of Birth: _____ Age: _____ Marital Status: Married Divorced Single Partnered Other

Home Address: _____
(Street) (City) (Zip Code)

Home Phone: _____ Cell Phone _____

E-mail address:_____ Occupation:_____

Employer (School, if Student)_____Work/School Phone:_____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Person's Phone Number:_____

Current Medications:_____

Allergies:_____

Prescribing Doctor:_____(Phone)_____

Responsible Party and/or Insurance Information

Name of Insured Person: _____ SS# _____ D.O.B _____

Primary Insurance Company: _____

Policy/Group Number: _____

Employer: _____ Work Phone: _____

Appointment Cancellation Policy: Positive Energy Solutions, Corp requires that cancellations for scheduled appointments be received 24 hours in advance. **Missed appointments which are not properly cancelled are subject to a missed appointment fee**, which can equal but not exceed the therapist's regular appointment fee. Insurance companies do not pay for missed appointment fees and the client is held fully accountable for this charge.

Insurance Billing: Patients are ultimately responsible for all charges, whether or not they are covered by your insurance.

Payment Policy: Positive Energy Solutions, Corp requires payment or co-payment for the services at the time they are rendered. Payment may be made by cash, check, debit or credit card. If you are utilizing insurance, by signing this form you are authorizing your signature on HCFA 1500 forms and any other forms required by your insurance for us to file a claim on your behalf. You are responsible for all costs not paid by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES OF POSITIVE ENERGY SOLUTIONS, CORP.

Signature of Responsible Party: _____