Dr. David Raque
11 Lenox Pointe, N.E., Suite A
Atlanta, Georgia 30324-7414

PATIENT INFORMATION FOR INDIVIDUAL THERAPY WITH DR. DAVID RAQUE

Name:____

Address:____

DOB:_________ **Age:**________ **if married, spouse's name:**_____________________________

Cell:________________________ **Email Address:**_______________________________________

Single: ____ **Married:** _____ **Other:** ________ **Who referred you?**_________________________

Have you ever been in individual therapy? ______ **If yes, how long ago and was it a positive experience?**____

Please check any of the boxes you feel concerned about and would like to address in therapy. Please put two (2) checks on those topics that are your priorities. If you want to be more specific, feel free to add to list.

___physical health issues
___addiction
___anger
___anxiety
___bereavement
___career goals
___children
___conflict resolution,
(If checked, with whom?
______________________)
___depression
___divorce/separation

___financial issues
___hopelessness
___in-laws
___insomnia
___job/career
___marriage difficulties
___motivation
___parenting
____self-esteem
___copying with stress
___relationship (If checked, with whom?______________________

___sexual difficulties
___stress
___suicidal thoughts
___trauma

What do you hope to accomplish in therapy?
____
____
____
____

PAYMENT FOR INDIVIDUAL THERAPY WITH DR. DAVID RAQUE

Dr. Raque's fee is $210 per 55 minute hour. Venmo (private), Zelle, ApplePay, or check at time of service.

My fee is based on the current competitive rate of other practicing clinical psychologists in the Metro Atlanta with my experience. For clients with HSA accounts, I will provide a statement at the end of every session for your records, if requested.

PAYMENT POLICY:

1. **Client accepts full financial responsibility for payment immediately following all services rendered.**

2. **Cancellations made within 24 hours of the scheduled appointment and/or no-shows will be subject to a full hourly charge.**

By signing, I certify that I have read the above agreement, that I understand it, and that I will adhere to it. My therapist has answered, to my satisfaction, all questions I have about these matters.

I hereby acknowledge that payment is expected at the time services are rendered. Failure to do so may result in my termination from this practice.

Please note that due to a previous experience, sessions are strictly prohibited from being recorded. No exceptions. Your signature below signifies your agreement to this policy.

Signed____ Date____________________________