

Dr. David Raque

11 Lenox Pointe, Suite A, Atlanta, GA 30324

INTAKE FORMS FOR COUPLES/RELATIONSHIP THERAPY

Name: _____ DOB: _____ Age: _____

Cell Phone: _____ Email: _____

Name: _____ DOB: _____ Age: _____

Cell Phone: _____ Email: _____

Relationship Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Name(s) and age(s) of children (If any):

1. _____ DOB: _____ Age: _____

2. _____ DOB: _____ Age: _____

3. _____ DOB: _____ Age: _____

Others if applicable _____

PAYMENT POLICY FOR COUPLES THERAPY

Fees: \$210.00 per hour. Venmo (private), Zelle, ApplePay, or check at time of service.

- 1. Client(s) accepts full financial responsibility for payment on all services rendered.**
- 2. Cancellations made within 24 hours of the scheduled appointment and/or no-shows will be subject to a full 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 termination of therapy.

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

Signed Date

COUPLES/RELATIONSHIP THERAPY COMMITMENT FORM TO TRUTHFULNESS

I, _____, am committed to being truthful during the process of our couples/relationship therapy with my spouse, Dr. David Raque and Susan Todd-Raque.

I, _____, am committed to being truthful during the process of our couples/relationship therapy with my spouse, Dr. David Raque and Susan Todd-Raque.

_____ Date