

**Dr. David Raque**

[www.drdauidraque.com](http://www.drdauidraque.com)

**404.233.0660**

**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: \$220.00 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**