Dr. David Raque

www.drdavidraque.com

404.233.0660

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

___financial issues

___hopelessness

___in-laws

___insomnia

___job/career

___marriage difficulties

___motivation

___parenting

____self-esteem

____coping with stress

___sexual difficulties

___stress

___suicidal thoughts

___trauma

What do you hope to accomplish in therapy?

____

____

____

___divorce/separation **____relationship (If checked, with whom?___________________**

PAYMENT FOR INDIVIDUAL THERAPY WITH DR. DAVID RAQUE

Dr. Raque's fee is $220 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 service 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_________________________