

Relationship Wellness Center

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CASE # _____

APPLICATION FOR SERVICES

Name: _____
(Last) (First) (Initial)

(Parent/Guardian (if minor) _____

Address: _____
Street (Apt #) City State Zip

Home Phone: _____ May we leave a msg ? Yes No

Off. Phone: _____ May we leave a msg ? Yes No

Cell Phone: _____ May we leave a msg ? Yes No

E-mail: _____ May we email you ? Yes No
(Email may not be confidential)

Please check the box if you would like to be on my mailing list to receive periodic articles of interest and my newsletter.

Emergency

Contact: _____
(NAME/RELATIONSHIP/CONTACT #)

Date of Birth: ____/____/____ Social Security # _____

MARITAL STATUS:

{ } Married { } Divorced { } Single { } Widowed { } Separated { } Remarried
{ } Partnered

REFERRED BY: _____

REASON FOR COUNSELING: _____

FEE AGREEMENT: Fees for services rendered are calculated at \$100.00 per 50-minute session, or upon the agreed amount contracted by both parties. Payment for services is due on the day the service is rendered. There will be a charge for the Full Rate (not contracted fee) for missed appointments that are not canceled 24 hours in advance. This charge is due and payable by the next session or within 7 days of the missed appointment, whichever comes first. Checks returned (NSF) will be subject to a \$25.00 charge, payable at the next session or within seven (7) days, whichever comes first (for more info see office policy).

SIGNATURE OF RESPONSIBLE PARTY: _____

Date: _____