



# Assessment and Counseling Services

Improving Quality of Life

xDate: \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security: \_\_\_\_\_ Sex: M / F Date of Birth \_\_\_\_\_

Home Phone: \_\_\_\_\_ (can we leave a message on answering machine? YES NO)

Work Phone: \_\_\_\_\_ (can we leave a message on answering machine? YES NO)

Cell Phone: \_\_\_\_\_ (can we leave a message on answering machine? YES NO)

Email Address: \_\_\_\_\_

## Statement of Understanding

### Patient's Consent:

I have read **Steven Snook, Ph.D., LLC's Policies and Practices to Protect the privacy of your Health Information**, and I both understand and approve of its content.

I hereby authorize Dr. Steven Snook, Ph.D., LLC to release the psychological evaluation report and to discuss all clinical information disclosed during the course of this evaluation as well as for billing purposes to Anglican Mission in the Americas: Rev. H Miller, Director of Leadership Development, and Patti Angulo, Administrative Assistant: Executive and Leadership Office

### Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on October 1, 2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice during your next session.

### Cancellation Policy:

In the event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by center staff at least 24 hours prior to the scheduled session will be billed at the usual hourly rate of \$120.00 Your insurance company will not pay for missed appointments.

Printed Name of Client: \_\_\_\_\_ Witness \_\_\_\_\_

Signature of Client and/or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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### Steven Snook, Ph.D., LLC and Associates

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