*Georgia Professional Counseling Center, Inc.*
*602 Abbey Court, Alpharetta, GA 30004*

Parent/Legal Guardian Questionnaire (Client ages 17 and under)
To be completed by the parent or legal guardian requesting services for a minor.
This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia law.

**Identifying Information:** Date:____________________

Name of Child:___________________________________DOB:____________Age:______

Home Address:_______________________________________________________________
City, State, Zip
Home Phone:____________________
May we leave a message?

Mother's Work Phone:_________________________
Mother's Cell Phone:__________________________
Can Mother be contacted at work? Y * N
Can Mother be contacted via cell phone? Y * N

Father's Work Phone:________________________
Father's Cell Phone:_________________________
Can Father be contacted at work? Y * N
Can Father be contacted via cell phone? Y * N

Mother's Employer:_________________________Occupation:_______________________

Father's Employer:__________________________Occupation:_______________________

If Divorced, for how long:____________

Legal Guardian:__________________________________Relationship:_________________

Referred by:____________________________________________________________________

Address, if known:_____________________________________________________________

May we mail a thank you letter to your referral source? ____________

**Billing Information:**

Party Responsible for Payment:__________________________
Relation to Child:_____________

**Family Information:**

| | Name | Age | Living with You? |
|---|---|---|---|
| Siblings | ______ | | Y or N |
| | ______ | | Y or N |
| | ______ | | Y or N |
| | ______ | | Y or N |
| Parents | ______ | | Y or N |
| | ______ | | Y or N |
| Other Family | ______ | | Y or N |
| | ______ | | Y or N |
| | ______ | | Y or N |
| | ______ | | Y or N |

Others living in home:______________________________________________

Religious affiliation:______________________________Active________Inactive_________

How significant is religion to your child's everyday life?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

**Medical History:**

List sicknesses, operations and injuries. Indicate age when occurred and describe how severe.
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Describe any physical problems your child or members of your household have which require medication or physical care:
_______________________________________________________________________
_______________________________________________________________________

______________________________________________________________________________
______________________________________________________________________________
___________________________________________________________________________

List any medications your child takes – prescription or over the counter:
______________________________________________________________________________
____________________________________________________________________________
______________________________________________________________________________
____________________________________________________________________________

Does your child have any allergies or adverse reactions to medication?
______________________________________________________________________________
____________________________________________________________________________
______________________________________________________________________________
____________________________________________________________________________

Primary Physician or other health care provider:
______________________________________________________________________________
____________________________________________________________________________

Office address and telephone:___________________________________________________

**Academic/School Information**

Name of School:__________________________________________________Grade:____

Has child ever repeated a grade?_______
If so, when?________________________________

How does the child get along at school?___________________________________________
______________________________________________________________________________
____________________________________________________________________________

Describe difficulties in learning at
school:______________________________________________________________________
______________________________________________________________________________
____________________________________________________________________________

Have other family members had learning difficulties?
______________________________________________________________________________
____________________________________________________________________________
______________________________________________________________________________
____________________________________________________________________________

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place two checks by those items which are most important.

_____Anger/Temper
_____Depression
_____Educational/School Work
_____Family Problems/Fighting with siblings
_____Fearfulness/Phobias
_____Sexual Concerns
_____Thoughts of Suicide
_____Weight loss or gain
_____Use of Alcohol
_____Use of Drugs

_____Insecure/Timid/Lack of Self Confidence
_____Marital Problems/Conflicts between parents, Divorce
_____Problems with accepting discipline
_____Problems in relationships with other children
_____Religious/Spiritual Concerns
_____Unhappy most of the time
_____Work
_____Worry
_____Physical Problems
_____Traumatic Stress
_____Stress

_____Other (Specify)____________________________________________________________
____________________________________________________________

Why did you decide to seek counseling for your child at this time?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

What do you think therapy is all about?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

How long do you expect your therapy to last?_________________________________________
______________________________________________________________________________

Has your child ever received counseling before? If so, when, why, and with whom?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

What goals do you hope for your child to accomplish by participating in therapy?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

In the past, has your child ever been the victim of or witnessed any type of traumatic event or incident?
If yes, please explain:_____________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

______________________________________________________________________________

Is there anything else which you believe or feel might be important for your counselor to know about your child?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Describe any method of discipline used and how the child reacts to such discipline:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Authorization for treatment:**

I declare that I am the custodial parent or legal guardian of the child described in this document and that I have the legal authority to bring him or her for treatment.

I authorize treatment to be administered by Georgia Professional Counseling Center, Inc.

**Parent/Legal Guardian Signature:**______________________________Date:__________

CLIENT NAME: ____________________________________________Age: ___________

**Georgia Professional Counseling Center, Inc.**
**Statement of Understanding**
**Client's Rights and Responsibilities**

TO BE SIGNED BY THE RESPONSIBLE PARTY FOR THIS CLIENT

**Program Description:** Georgia Professional Counseling Center, Inc. is staffed by trained and experienced psychotherapists. Our staff's goal is to provide quality, caring and professional services to our clients and their family, regardless of the client's race, ethnic origin, religion, creed, gender, age disability status, or sexual orientation.

## CLIENT RIGHTS

**Confidentiality:** Everything you say to your therapist is confidential and cannot be shared with anyone outside this office without your permission. Your therapist cannot release any information about you without a signed *consent for release of information*, except in emergencies or when there is a court order, determination or law requiring the information be released. By my signature below, I agree not to hold Georgia Professional Counseling Center, Inc. liable for such disclosure.

**Duty to Warn:** Information about dangerous behaviors, including serious thoughts of hurting yourself or another person, as well as information about possible child abuse, is not confidential and will be reported by your therapist to the appropriate authorities to keep you and other people safe. Also, if you are referred to counseling by a court order, information about your treatment is not confidential and can be released to the Court without your consent.

**After Hour Emergencies:** Georgia Professional Counseling Center, Inc. **DOES NOT** provide 24-hour coverage for client emergencies. If a life-threatening emergency should arise after hours, you should call 911 or travel to the nearest emergency room. If you need to talk to a counselor urgently but the need is not life threatening, you may call the Georgia Professional Counseling Center, Inc. main number (678-910-3851).

**Appointments:** You are responsible for confirming and rescheduling your next appointment date and time.

**24-HR Cancellation Policy:** 24-hour notice is required for cancellations, since your therapist reserves time for you when you schedule an appointment. If you do not cancel **24 hours in advance**, you will be charged a **$100.00 late cancellation fee.** ***NOTE:*** You may leave a message on the Georgia Professional Counseling Center, Inc. main number (678-910-3851) during or after regular business hours and on weekends to cancel an appointment. If your therapist cancels the appointment with less than 48-hour notice, your account will be credited $100.00. We believe it should go both ways because your time is valuable too!

**Missed Appointment Charge: You will be charged a $100.00** for a missed appointment.

**Fee Payment:** You are responsible for paying your session fee unless other payment arrangements have been made with your therapist. Billed balances are due upon request for payment.

**Collection of Delinquent Accounts:** A delinquent balance will be cause for your account to be classified as a bad debt and forwarded to a collection or legal agency for immediate action. Any charges incurred by Georgia Professional Counseling Center, Inc. for the collection of the delinquent balance will be your responsibility. In the case of a Court Order, determination, or law requiring the account information be released, my signature below states that I agree not to hold Georgia Professional Counseling Center, Inc. liable for such disclosure.

**Returned Check Charges:** Your account will be charged a **$75 returned check fee** for NSF checks. This fee and the outstanding balance will be due upon request.

**Timely Notification of Changes:** You are responsible for notifying our office of any change in your address, telephone number, employment and insurance carrier information prior to your next appointment.

*My signature below indicates that I have been informed of my rights and responsibilities, and that I understand this information. I understand that it is my sole responsibility to request clarification or additional information concerning my rights and responsibilities.*

______________________________________________________________

*Signature of Client / Parent / Legal Guardian / Other* *Date*

*Address:* ______________________________________________

*State:* ______________ *ZIP:* ______________ *Tel:* ______________________

*Employer:* ___________________________ *Tel:* ______________________

**Georgia Professional Counseling Center, Inc.**
**SELF-PAYMENT AGREEMENT**

## Responsible Party Information:

**I,**_____________________________________________________________
PRINT FULL NAME
am the responsible party for: __________________________________________________________
PRINT CLIENT NAME

## Identifying Information:

Date:__________________

Name:___________________________________DOB:________________Age:_____

Home Address:____________________________________________________________
City, State, Zip
Home Phone:__________________
Work Phone:___________________ Cell Phone:__________________

A payment of **$100.00** will be made ***each visit*** before services are rendered. Initial here to acknowledge you agree_____.

I am aware that payments may be rendered via Cash or Personal Check. I will be charged a fee of **$75.00 for NSF checks.** This fee and the past due amount is due upon request for payment. Initial here to acknowledge you agree_____.

**24-Hour Cancellation Policy:** 24-hour notice is required. If I do not cancel 24 hours in advance, I will be charged a **$100.00 late cancellation fee**. Charges are due upon request for payment. Initial here to acknowledge you agree_____.

**Missed Appointment Charge:** I will be charged a **$100.00 fee for a Missed Appointment.** I am responsible for notifying Georgia Professional Counseling Center, Inc. Charges are due upon request for payment. Initial here to acknowledge you agree_____.

I am aware that I am responsible for notifying Georgia Professional Counseling Center, Inc. of any changes in my mailing address, telephone numbers and employment. Initial here to acknowledge you agree_____.

I am aware that in the event of default of payment on this account, my account may be turned over to an outside collection agency or legal representative for collection. Any additional costs incurred by Georgia Professional Counseling Center, Inc. to collect the outstanding balance will become my responsibility. Initial here to acknowledge you agree_____.

I am aware that I am responsible for notifying Georgia Professional Counseling Center, Inc. of any changes in my mailing address, telephone numbers and employment. Initial here to acknowledge you agree_____.

I am aware that all billing correspondence with the Georgia Professional Counseling Center, Inc. will be handled electronically. If I request a receipt it will be sent to me electronically. Invoices with outstanding balances may be sent to me electronically as well. **Please provide the Georgia Professional Counseling center with your email address which will use for billing purposes only.**

**EMAIL ADDRESS for billing and receipts:**____________________________________________

I am aware that the Georgia Professional Counseling Center, Inc. cannot guarantee the security of electronic communication. Please initial here to acknowledge you agree to allow the Georgia Professional Counseling Center, Inc. to communicate with you electronically for billing purposes only_____.

All questions related to billing may be forwarded to the Georgia Professional Counseling Center, Inc. billing department at the following email address: billing@georgiaprofessionalcounselingcenter.com

*My signature below indicates that I have been informed of my rights and responsibilities, and that I understand this information.*

*Signed:* _______________________________ *Date:* ________________________

**Effective 01/01/2006**
**Georgia Professional Counseling Center, Inc. Policies and Practices to Protect the Privacy of Your Health Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

- *Adult and Domestic Abuse* – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

- *Health Oversight Activities* – If I am the subject of an inquiry by the Georgia Composite Board of Licensed Professional Counselors, I may be required to disclose protected health information regarding you in proceedings before the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege

does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

## IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with a revised notice via U.S. regular mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact John H. Pruett, Jr., Compliance Officer, at 770-656-9711.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to the attention of your therapist's name c/o John H. Pruett, Jr., Compliance Officer at Georgia Professional Counseling Center, Inc. at 602 Abbey Court, Alpharetta, GA 30004

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1st , 2006.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by U.S. Regular Mail.

Print Client Name: ____________________________________________________________

_____________________________________________________________________________
Signature                                                                                    Date
Patient (18 Years and older) / Legal Guardian

_____________________________________________
Print Name

_______ I would like a copy.          ________ I decline a copy of this document.

## Child and Adolescent Symptoms and Behavior Checklist

| | **Symptoms and behaviors** | **Ages 0-2** | **Ages 3-5** | **Ages 6-8** | **Ages 9-11** | **Ages 12-13** | **Ages 14-16** | **Ages 17-19** |
|---|---|---|---|---|---|---|---|---|
| 1 | Bedwetting | | | | | | | |
| 2 | Night Terrors | | | | | | | |
| 3 | Excessive worry about harm befalling parents | | | | | | | |
| 4 | Excessive distress when separated from family | | | | | | | |
| 5 | Temper Tantrums | | | | | | | |
| 6 | Extreme clingy behavior | | | | | | | |
| 7 | Repeated complaints of physical symptoms | | | | | | | |
| 8 | Has marked changes in appetite | | | | | | | |
| 9 | Often has cravings for carbohydrates or sweets | | | | | | | |
| 10 | Periods of extreme sadness | | | | | | | |
| 11 | Elevated or irritable mood > 1hr/day | | | | | | | |
| 12 | Elevated or irritable mood > 6 hrs/day | | | | | | | |
| 13 | Elevated or irritable mood > 2 days | | | | | | | |
| 14 | Depressed Mood > 1 hr/day | | | | | | | |
| 15 | Depressed Mood > 6 hrs/day | | | | | | | |
| 16 | Depressed mood 1-2 days in duration | | | | | | | |
| 17 | Depressed mood> 2 days in duration | | | | | | | |
| 18 | Has suicidal thought often | | | | | | | |
| 19 | Has cut self with | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | sharp instrument | | | | | | | |
| 20 | Has made suicide attempt | | | | | | | |
| 21 | Has difficulty getting to sleep at night | | | | | | | |
| 22 | Often awakens in the middle of the night | | | | | | | |
| 23 | Frequently oversleeps | | | | | | | |
| 24 | Has decreased need for sleep | | | | | | | |
| 25 | At times has very fast speech | | | | | | | |
| 26 | Thoughts race/has many ideas at once | | | | | | | |
| 27 | Has wide swings in mood | | | | | | | |
| 28 | Often does not seem to listen when spoken to | | | | | | | |
| 29 | Often takes excessive risks | | | | | | | |
| 30 | Is easily distracted by extraneous stimuli | | | | | | | |
| 31 | Has periods of inflated self-esteem or grandiosity | | | | | | | |
| 32 | Has engaged in unrestrained buying sprees | | | | | | | |
| 33 | Often blurts out answers to questions | | | | | | | |
| 34 | Has difficulty engaging in playful activities | | | | | | | |
| 35 | As a newborn, extremely irritable and difficult to settle | | | | | | | |
| 36 | Is extremely sensitive to sensory stimuli | | | | | | | |
| 37 | Often has difficulty | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | organizing tasks | | | | | | | |
| 38 | Often loses things necessary for tasks | | | | | | | |
| 39 | Often is reluctant to engage in tasks | | | | | | | |
| 40 | Often fidgets with hands or feet | | | | | | | |
| 41 | Often leaves seat in classroom | | | | | | | |
| 42 | Often has difficulty awaiting turn | | | | | | | |
| 43 | Often interrupts or intrudes on others | | | | | | | |
| 44 | Demonstrates an inability to concentrate at school | | | | | | | |
| 45 | Frequently attempts to avoid school | | | | | | | |
| 46 | Illicit drug use | | | | | | | |
| 47 | Alcohol use | | | | | | | |
| 48 | Migraine headaches | | | | | | | |
| 49 | Speech difficulties (specify) | | | | | | | |
| 50 | Panic symptoms—marked anxiety attacks | | | | | | | |
| 51 | Excessive anxiety or worry | | | | | | | |
| 52 | Anxiety causes impairment in social functioning | | | | | | | |
| 53 | Fear of closed spaces | | | | | | | |
| 54 | Fear of animals | | | | | | | |
| 55 | Fear of heights | | | | | | | |
| 56 | Fear of crowded places | | | | | | | |
| 57 | Hears voices | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 58 | Paranoid thinking | | | | | | | |
| 59 | Bizarre Behavior (specify) | | | | | | | |
| 60 | Recurrent anxiety-producing thoughts or impulses | | | | | | | |
| 61 | Repetitive mental acts (counting, repeating words silently) | | | | | | | |
| 62 | Frequent and repetitive checking behavior | | | | | | | |
| 63 | Frequent and repetitive hand washing | | | | | | | |
| 64 | Tics: Recurrent stereotyped movements or vocalizations | | | | | | | |
| 65 | Frequently lies | | | | | | | |
| 66 | Deliberately set fires | | | | | | | |
| 67 | Is frequently mischievous | | | | | | | |
| 68 | Often bullies, threatens, or intimidates others | | | | | | | |
| 69 | Often initiates physical fights | | | | | | | |
| 70 | Has deliberately destroyed other's property | | | | | | | |
| 71 | Has broken into someone's house | | | | | | | |
| 72 | Often lies to obtain goods or favors | | | | | | | |
| 73 | Often stays out at night against curfew | | | | | | | |
| 74 | Has run away from home overnight at | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | least twice | | | | | | | |
| 75 | Is often truant from school | | | | | | | |
| 76 | Often loses temper | | | | | | | |
| 77 | Often defies or refuses to comply with rules | | | | | | | |
| 78 | Often argues with adults | | | | | | | |
| 79 | Often blames others for his or her mistakes | | | | | | | |
| 80 | Is often touchy or easily annoyed by others | | | | | | | |
| 81 | Is often angry and resentful | | | | | | | |
| 82 | Has fear of social or performance situations | | | | | | | |
| 83 | Increased sexual interest | | | | | | | |
| 84 | Increased sexual behavior | | | | | | | |
| 85 | Fascination with death and gore | | | | | | | |

*Georgia Professional Counseling Center, Inc.*
*602 Abbey Court, Alpharetta, GA 30004*

**Directions & Parking**

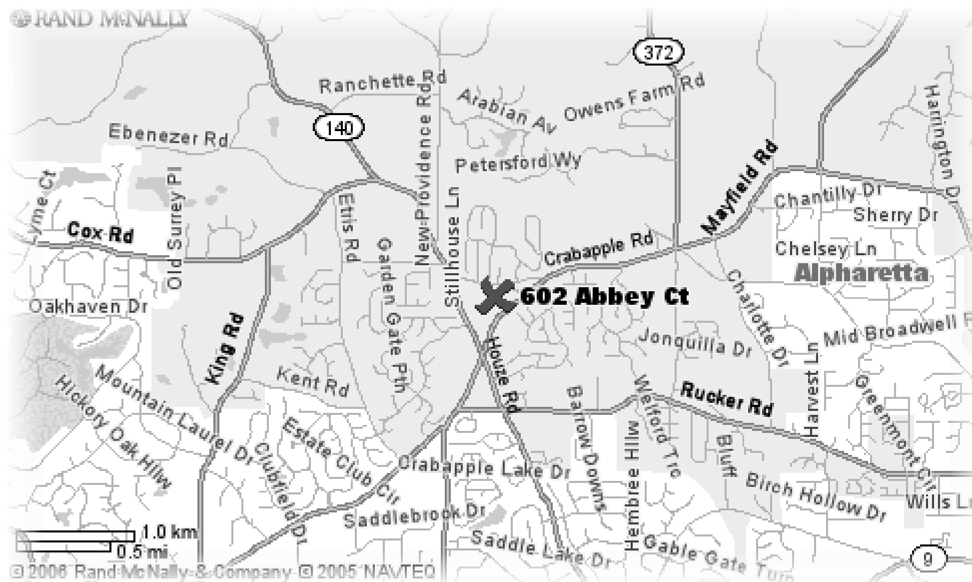
**We are located 602 Abbey Court, Alpharetta, GA 30004**

***From Atlanta: Take Interstate 400 Northbound to Exit 7B/Roswell/Hwy 140 Exit. Turn right onto Holcomb Bridge Road. Continue on Holcomb Bridge Road for 1.6 miles. Continue on East Crossville Road for 1.3 miles. Then bear right onto Crabapple Road and continue on Crabapple Road for 2.8 miles. Then turn left onto Abbey Court and you will be in the Crabapple Village Office Park. Turn into the 3rd street on your left and we are located in building 602.***

***From Cumming: Take Interstate 400 Southbound to Exit 10. Bear right onto the GA-120 West ramp for .1miles, then bear right onto Old Milton Parkway and continue on Old Milton Parkway for 2.2 miles. Then continue on Rucker Road for 2.6 miles. Then turn right onto Houze Road and continue on Houze Road for .3 miles. Then bear right onto Crabapple Road and continue on Crabapple Road for .4 miles. Then turn left onto Abbey Court and you will be in the Crabapple Village Office Park. Turn into the 3rd street on your left and we are located in building 602.***

***From Downtown Woodstock: Take Arnold Mill Road east for 12 miles. Then turn left onto Crabapple Road and continue on Crabapple Road for .1 miles. Then turn left onto Abbey Court and you will be in the Crabapple Village Office Park. Turn into the 3rd street on your left and we are located in building 602.***

***From Canton: Take Highway 140/Hickory Flat Highway toward Alpharetta/Roswell for 15 miles. Then turn left onto Crabapple Road and continue on Crabapple Road for .1 miles. Then turn left onto Abbey Court and you will be in the Crabapple Village Office Park. Turn into the 3rd Street on your left and we are located in building 602.***




*www.gaplaytherapy.com*
*Phone: 678-910-3851*