Ephrat L. Lipton, ACSW, LCSW, BCD, CEDS
6100 Lake Forrest Dr., Suite 450, Atlanta, GA 30328
ephratlipton@gmail.com (404) 202-0932

Date___________________ Referral Source___________________________

Patient Name ______________________________ Date of Birth ___________

Address ____

City__________________ State__________________ Zip Code____________

Home phone ______________________ Cell phone______________________

Email address____

Social Security Number___________________________

Place of Employment ______________________________ Work Phone_____________

Financially Responsible Party

Name______________________________ Relation_____________ Date of Birth_________

Address____

City___________________________ State_________________ Zip Code________________

Home/cell phone_____________________ e-mail_________________________________

Medical Information

Allergies____

Current Medications ____

Psychiatrist or prescribing Dr. ____

I hereby authorize treatment by Ephrat L. Lipton, ACSW, LCSW, BCD, CEDS. I understand that I am financially responsible for all services regardless of insurance benefits. I authorize Ephrat L. Lipton ACSW, LCSW, BCD, CEDS to release information to process and secure payment for services. Full fees will be charged for appointments not cancelled 24 hours in advance (48 hours for weekend appointments).

Patient or Guardian Signature____

Financially Responsible Party____