Ginair Goodwin McKerrow
6100 Lake Forrest Dr., Suite 450, Atlanta, GA 30328
GinairLCSW@gmail.com (404) 983-3320

Date_____ Referral Source_____
Client Name _____ Date of Birth _____
Address _____
City_____ State_____ Zip Code_____
Home phone _____ Cell phone_____
Email address_____
Place of Employment _____Work Phone_____
*What is your preferred form of communication_____
Of your preferred form of communication, with you permission may I leave confidential voice, text or email message?_____
_____

Financially Responsible Party
Name_____ Relation_____ DOB_____
Address_____
City_____ State_____Zip Code_____
Home/cell phone_____
e-mail_____

Medical Information
Allergies_____
Current Medications _____
Psychiatrist or prescribing doctor_____

I hereby authorize treatment by Ginair Goodwin McKerrow, LCSW. I understand that I am financially responsible for all services regardless of insurance benefits. I authorize Ginair Goodwin McKerrow, LCSW 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_____
FinanciallyResponsibleParty_____