Hilary Woodman, LCSW
6100 Lake Forrest Dr., Suite 450,
Atlanta, GA 30328

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_____________________ Status:

Household members currently living with you____

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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 Hilary Woodman, LCSW, I understand that I am financially responsible for all services regardless of insurance benefits. I authorize Hilary Woodman, 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:__________________________________Date:_________________________

Financially Responsible Party:__________________________________Date:_________________________