Joanne M. Pulley, MS, LPC

6100 Lake Forrest Drive, Suite 450

Atlanta, GA 30328

Date _____

Patient Name _____

Referral Source _____

Date of Birth_____

Address_____

City _____ State _____ Zip Code_____

Home Phone _____ Cell Phone _____

Social Security Number _____

Place of Employment _____

Work Phone _____

Responsible Party

Name _____

Date of Birth _____

Address (if different than above) _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone_____

Medical Information

Allergies

_____

Current Medications and dosages

_____

_____

Primary Care Physician:_____ Phone Number: _____

Psychiatrist _____ Phone Number: _____

I hereby authorize treatment by Joanne M. Pulley, MS, LPC. I understand that I am responsible for all services regardless of insurance benefits. I authorize Joanne M. Pulley, MS, LPC to release information to process and secure payment for services.

Full fee will be charged for appointments not cancelled twenty-four hours in advance during the week and forty-eight hours on the weekends.

Patient or Guardian Signature _____

Responsible Party _____

Date _____