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: Seperated

Household members currently living with you_____

_____

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:_____