

Ginair Goodwin McKerrow, LCSW., LLC.
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 _____

Emergency Contact (name/number)

**I give permission for Ginair Goodwin McKerrow to contact emergency
contact in case of an emergency. Client signature _____**

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 _____