Jo Raphael, LCSW, ACSW, BCD
6100 Lake Forrest Dr., Suite 450, Sandy Springs, GA 30328
Phone: 404.291.9181

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_____

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. _____

Contact Information_____

I hereby authorize treatment by **Jo Raphael, LCSW, ACSW, BCD**. I understand that I am financially responsible for all services regardless of insurance benefits. I authorize **Jo Raphael, LCSW, ACSW, BCD** 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_____

Financially Responsible Party_____