Chip Abernathy, LPC
6100 Lake Forrest DR, Suite 450
Atlanta, GA 30328
Phone (770) 862-7585

CONFIDENTIAL PATIENT INFORMATION

Last Name: _____ First: _____ Middle: ____
Street Address: _____
City/State/Zip: _____
Date of Birth: _____ Social Security Number: _____
Age: _____ Male/Female: _____ Marital Status: _____
Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____
Employer Address: _____
Work Phone: _____

Spouse or Next of Kin: _____ Phone: _____
Address: _____
In Case of Emergency Contact: _____ Phone: _____

Referred by: _____ Phone: _____
Permission to contact them: Yes/No: _____

List primary reason for seeking counseling or psychotherapy

_____
_____

List any other current mental health care providers (Names and specialties): _____
_____

Guaranty of Payment: Office visits are payable at time of service. Fees for appointments not canceled at least 24 hours in advance are payable in full the next business day.

Release of Information: I authorize the release of information to other attending health care providers if needed. I authorize the release of information to insurance carriers if insurance is filed and I request that information be released. I certify that the above information is correct.

I have read, understand, and agree to the terms of the above paragraphs.

_____/_____ _____
Signature of patient | Signature of parent or guardian (If patient is under 18 years old) | Date