MICHELLE MORRIS, LPC
6100 Lake Forrest Dr., Suite 450, Atlanta, GA 30328
MichelleMorrisLPC@gmail.com
814.932.1120

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. ____

I hereby authorize treatment by Michelle Morris, LPC. I understand I am financially responsible for all services regardless of insurance.

Patient Signature ____

Financial Responsive Party ____