**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 a medical emergency or if you are harm to self or others.**
**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________________________________________________________