6100 Lake Forrest Drive, Suite 450 Atlanta, GA 30328

Providers Name _____

Date_____ Patient Name _____

Referral Source_____

Identified Gender/Preferred Pronouns _____Date of Birth_____

Address _____

Home Phone_____ Can we leave a message? Y N

Cell Phone _____ Can we leave a message? Y N Can we leave a text message? Y N

Email Address _____ Can we email you? Y N

Please list any other family members that may be involved in the therapy (in family therapy, etc.)

Name	Date of Birth	Phone, Email, and/or Address if different

Financially Responsible Party (Parent if Patient is a Minor)

Name _____ Relation_____

Address_____

Preferred Phone number _____

Email _____

Medical Information

Current Medications _____

Prescribing Doctor _____

I hereby authorize treatment by_____. I understand that I am responsible for all services regardless of insurance benefits or reimbursement. I authorize the billing department of Atlanta Center for Wellness to release information to process and secure payment for services.

*__*FULL FEE*__ will be charged for appointments not cancelled twenty-four hours in advance. *All billing questions should be sent to **ac4wbilling@gmail.com**

Patient or Guardian Signature _____

Financially Responsible Party _____