Comprehensive Outpatient Program for Eating Disorders (COPE™) at AC4W

6100 Lake Forrest Drive, Suite 450 Atlanta, GA 30328

phone: (404) 343-4162 fax: (404) 549-9316 email: admin@atlantacenterforwellness.com

Date_____ Client Name _____

Identified Gender/Preferred Pronouns_____

Client Date of Birth_____

Referral Source_____May we contact them? Y N

Referral Source Contact Info: _____

Client Address_____

Home Phone_____ Can we leave a message? Y N

Cell Phone _____Can we leave a message? Y N Text message? Y N

Can we email you? Y N Email Address _____

Please list any other family/support people who may be involved in the therapy (in family therapy, etc.) and/or at least one emergency contact (please indicate emergency contact person with *).

Name of Support Person	Relationship to Client	Phone Number and Email of Support Person

Financially Responsible Party (Parent, if Patient is a Minor)

Name _____ Relation_____

Address_____

Preferred Phone number _____

Email _____

*__All__ COPE™ participants must provide a credit card which will be kept securely on file and which will be charged for each group. There is a 2.6% credit card fee for each transaction.

Credit card information: CC#_____ CVV_____

Exp date:_____ Billing address (with zip code) _____

_____

Medical Information

Current Medications _____

Prescribing Doctor _____

I hereby authorize treatment by and communication between all AC4W/COPE™ clinicians. I understand that the program/all groups offered are an outpatient level of care and cannot substitute for medical supervision or higher levels of care. These groups are intended to compliment other outpatient services such as individual and family therapy. There is no guarantee that symptoms will remit as a result of this treatment. I understand that I am financially responsible for all services, regardless of insurance benefits or reimbursement. I authorize the billing department of AC4W to charge the credit card on file for groups that are registered for and to release information in order to process payments and assist in securing payment for services.

We will be capping the participants of the groups to promote quality of care. Once a group is full, others will not be able to sign up for and take that group. Therefore, reserving a spot is a commitment.

*__FULL FEE__ will be charged for appointments/groups not cancelled twenty-four hours in advance, regardless of the reason. Please initial indicating that you understand the cancellation policy: _____

*All billing questions should be directed to Kim Frey, our billing representative at AC4Wbilling@gmail.com

Patient or Guardian Signature _____

Financially Responsible Party _____