Ken Sherman, MSW, LCSW Shermanpsychotherapy@gmail.com

6100 Lake Forrest Drive, Suite 450 Atlanta, GA 30328 (470) 572-3547

Date_____ Patient Name _____

Referral Source_____

Identified Gender and 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 Ken Sherman, MSW, LCSW. 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, LLC 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 Kim Frey, admin, at AC4Wbilling@gmail.com or 678-984-6722

Patient or Guardian Signature _____

Financially Responsible Party _____

We are now sending monthly statements via email please confirm the email where you want to receive them:

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