



Rachel Hopkins, MS, CRC, LAPC [counselingwithrachelhopkins@gmail.com](mailto:counselingwithrachelhopkins@gmail.com)

6100 Lake Forrest Drive, Suite 450 Atlanta, GA 30328 (470) 737-0875

Date \_\_\_\_\_ Patient Name \_\_\_\_\_

Referral Source \_\_\_\_\_

Identified Gender and 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 Rachel Hopkins, MS, CRC, LAPC. 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 forty-eight hours in advance.

\*All billing questions should be sent to Kim Frey, admin, at [AC4Wbilling@gmail.com](mailto: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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