

Chip Abernathy, LPC

1260 Concord RD, Suite 205, Smyrna, GA 30080. Phone (770) 862-7585

CONFIDENTIAL PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____

Street Address: _____

City/State/Zip: _____

Date of Birth: _____ Social Security Number: _____

Age: _____ Male/Female: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____

Spouse or Next of Kin: _____ Phone: _____

Address: _____

In Case of Emergency Contact: _____ Phone: _____

Referred by: _____ Phone: _____

Permission to contact them: Yes/No: _____

List primary reason for seeking counseling or psychotherapy

List any other current mental health care providers (Names and specialties):

Guaranty of Payment: Office visits are payable at time of service. Fees for appointments not canceled at least 24 hours in advance are payable in full.

Release of Information: I authorize the release of information to other treating health care providers if needed. I authorize the release of information to insurance carriers if insurance is filed and I request that information be released. I certify that the above information is correct.

I have read, understand, and agree to the terms of the above paragraphs.

_____/_____
Signature of patient Signature of parent or guardian Date
(If patient is under 18 years old)