Chip Abernathy, LPC LLC
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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 (If patient is under 18 years old) | Date