PSYCHOTHERAPY ASSOCIATES

MICHELLE MORRIS, LPC
6000 Lake Forrest Dr., Suite 400, Atlanta, GA 30328
MichelleMorrisLPC@gmail.com 814.932.1120

Date__________________ Referral Source_________________________ Patient Name
____________________________ Date of Birth ___________ Address
____ City________________
State________________ Zip Code___________

Home phone ____________________ Cell phone____________________
Email address____
Social Security Number_________________________
Place of Employment ____________________________ Work Phone____________

Financially Responsible Party

Name____________________________ Relation____________ Date of Birth________
Address____
City_________________________ State_______________ Zip Code______________
Home/cell phone___________________ E-mail______________________________

Medical Information

Allergies____

Current Medications ____

Psychiatrist or prescribing Dr. ____

I hereby authorize treatment by Michelle Morris, LPC. I understand I am financially responsible for all services regardless of insurance.

Patient Signature

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Financial Responsive Party

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