Sarah A. Roe, LCSW

Brookwood Exchange
1708 Peachtree Street, NW
Suite 415
Atlanta, GA 30309
404-815-0897 p

Client Information Form

Please bring with you on your first visit.

Name

City State Zip

Address

Age Date of Birth

Address 2

Fill in info where messages can be left for you:

Work

Home

Cell

Email

Employer

Position How long?

Referred by

May I thank the referral source? ❒ Yes ❒ No

Emergency Contact

Relationship

Daytime Phone Number

Evening Phone Number

Initial here for permission to contact in case of emergency _____

Insurance Provider

Group Number

Member ID

Name of Insured

Insured's Date of Birth

Relationship

Insured's Address & Phone Number (if different than client)

Deductible

Co-pay

Insurance Telephone Number

Flex Spending Account: ❒ Yes ❒ No

Monthly statement required: ❒ Yes ❒ No

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Please bring with you on your first visit.

Primary Care Physician _____ Phone number _____

May I contact them if clinically necessary? ❒ Yes ❒ No

List any medical conditions or current physical symptoms or difficulties:

List current prescription and non-prescription medications:

Previous therapy experience (therapist, dates of treatment):

Fees are due at time of service. If using a managed care plan, you are responsible for your deductible and co-pay. If I am an out-of-network provider, you are responsible for your bill with me, and the insurance company is responsible for reimbursing you. I have a 24-hour cancellation policy. You will be charged for sessions cancelled without 24 hours notice. These fees are not covered by insurance.

Insurance billing for Sarah A. Roe, LCSW is performed by Peachtree Professional Services, LLC, who operates under the privacy requirements specified by HIPPA.

Signature below authorizes Sarah A. Roe, LCSW to release all necessary information to Peachtree Professional Services, LLC, for the purpose of billing the insurance company designated above. Signature further serves as permission for the insurance company to pay benefits to Sarah A. Roe, LCSW for services provided. Signature also authorizes release of pertinent clinical information by Sarah A. Roe, LCSW to the designated insurance company in order to obtain additional sessions as needed. This authorization remains in effect until satisfaction of outstanding balance for services provided while insured by the designated insurance company.

Signature _____ Date _____