J. Alan Graham, Ph.D.

1780 Century Blvd., NE ♦ Suite A ♦ Atlanta, Georgia 30345
Phone 404/325-8900

Confidential

Today's date _____

Name _____ Date of Birth_____ Age_____

Who referred you ?_____
May I contact this person to let them know we have met? _____

Phone Numbers:
Home: _____ Message can be left? yes____ no____
Business:_____ Message can be left? yes____ no____
Other: _____ Message can be left? yes____ no____
Email: _____ (email is for scheduling appointment only as confidentiality cannot be assured)

Present Address_____
(Street)

_____
(City) (State) (Zip Code)

Medical history

Physician:_____ May I contact him/her if it would be helpful to do so?_____

Medical conditions, symptoms, or concerns_____
_____
_____

Current Prescription Medications:_____
_____

Psychotherapy History

Currently in Counseling or Psychotherapy: Yes__ No__
If yes, where?_____ When:_____
Name of Therapist_____ May I contact him/her? _____

Previous Counseling or Psychotherapy? Yes__ No___
If yes, Name of Therapist_____ When:_____For How Long?_____
May I contact him/her? _____

What was this experience like?_____

Medication Prescribed? Yes__ No__ If yes, what type?_____

Have you had feelings of hurting yourself or anyone else?_____

Psychiatric Hospitalization? Yes__ No__ If Yes, when:_____where? _____

Family History

Have any of your family members been hospitalized for psychiatric purposes? _____
_____

Has alcoholism or drug addiction been an issue in your family history? _____
_____

Is alcohol or drug use a concern you want to discuss?_____
_____

Emergency Contact Person*

Name _____
Relationship to you_____
Address_____
Home Phone_____ Work Phone_____

NOTE: This person would only be contacted upon life threatening circumstances and if you were unable to give your consent.

Briefly describe what you hope will happen or be different as a result of psychotherapy.

Financial Information

Person responsible for your bill: _____

1. Payment is expected at the time of service unless other arrangements have been made. Fees for an individual or couple 50 minute session is $250.00. Group sessions are $60.00 per group.

2. Because an appointment is a time reserved for you, payment is expected for appointments missed or canceled less than 24 hours in advance. This does not apply to group sessions.

3. By signing this form, I give consent to Dr. Graham and/or his billing agent to release information to insurance agencies for the purpose of payment for sessions and authorizations for additional sessions (when applicable). I understand that electronic filing for claims may be used and that Dr. Graham and/or his billing agent take every effort to insure my privacy.

Signature indicating I have read the above and understand the nature of these arrangements:

_____

My preferred method of payment is to Zelle to my email, jalangraham@gmail.com. If you are unable to Zelle, you can indicae your Credit Card information below.

Credit Card Authorization:

_____ _____

credit card number expiration date

_____

Signature approving authorization for Credit Card charges as well as for sessions missed or not cancelled 24 hours in advance.

No charge will be made to your credit card if you cancel your appointment with 24 hours notice.