Constance L. Cromartie, LPC, NCC
700 Old Roswell Lakes Parkway*Suite 230*Roswell, GA*30076
Telephone: 678-995-4442 Fax: 678-878-3500

Today's Date:_____

Patient Information (***Please Print***) **Name of Patient:** _____, _____, _____ *Last, First, Middle*	**Date of Birth:** _____ *mm/dd/yyyy*
Address of Patient: _____ *Street number and name* _____ *City, State, Zip Code*	**Telephone no.** _____ *(area code)* _____-_____ *xxx-xxxx*
Email:	**Gender: M F** *(circle one)*
SSN:	
Parent/Guardian information, if patient is under the care of a parent/guardian: **(*Please Print)* Name of Parent/Guardian:** _____, _____, _____ *Last, First, Middle*	**Date of Birth:** _____ *mm/dd/yyyy*
Address of Parent/Guardian: _____ *Street number and name* _____ *City, State, Zip Code* **Email:**	**Telephone no.** _____ *(area code)* _____-_____ *xxx-xxxx*
SSN:	**Gender: M F** *(circle one)*
Counseling fee amount: $_____	
Cash: _____ Check: _____ Credit/Debit/Flex Card: _____	
Credit/Debit Card Type (i.e. *Master Card, Visa, Discover, Amer. Exp.)*	
Credit/Debit Card number:	
CVV (3-digit security code):	
Expiration Date: *(mm/dd/yyyy)* _____	**Office Use Only:**

I authorize Constance L. Cromartie, LPC to charge my credit/debit/flex card on my behalf to receive payment for services rendered. I understand that I am responsible for any portion of fees that is not covered, and that payment is due on date of service.

Signature of card holder:

_____ Date: _____