Michael W. McNulty, LPC
700 Old Roswell Lakes Parkway, Suite 300
Roswell, GA 30076
770-289-8217
Mike@MikeMcNultyLPC.com

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Preferred first name: _____ Is patient 18 or older? ❑ Yes ❑ No

Address: _____
Street address/apt. # City, State ZIP

Phone: _____
- Confidential **voice** messages can be left at this phone number: ❑ YES ❑ NO
- Confidential **text** messages can be sent to this phone number: ❑ YES ❑ NO

Email: Confidential **email** messages can be sent to my email: ❑ YES ❑ NO

If YES, use this email address: _____

TeleMental Health: I agree to video conferencing: ❑ YES ❑ NO

How did you learn about my practice: ❑ Psychology Today web site ❑ Insurance web site
❑ MikeMcNultyLPC.com web site ❑ Other: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: _____

INSURANCE INFORMATION

❑ I'll be self-paying.
❑ I'll be using insurance where I'm the primary insured person. Insurance Company: _____
❑ I'll be using insurance where I'm a dependent.
If you check the last option, complete the following: Insurance Company: _____

Insured's Name: _____ DOB: _____

Address: _____
(If different than patient address) Street address/apt. # City, State ZIP

❑ I also have secondary insurance.
If you check this option, complete the following: Insurance Company: _____

Insured's Name: _____ DOB: _____

Address: _____
(If different than patient address) Street address/apt. # City, State ZIP

AUTHORIZATION

*Please read and **INITIAL** each item.*

_____ I authorize my insurance company to pay Michael W. McNulty, M. Div., LPC, directly for any services rendered to me by him. I authorize the release of any information required for the processing of claims or the authorization of sessions.
_____ I've read and understand the Patient/Therapist Agreement.
_____ I've read and understand the Notice of Privacy Practices.

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_____ _____

Signature (Guardian's signature if patient is under 18) Date