



CLIENT INFORMATION

(Please Print Clearly)

Client Name: _____
Last First Date of Birth: (MM/DD/YYYY) Age

Names of others within the family that may also participate in family therapy (I confirm that I am the legal guardian of anyone under the age of 18 who will participate in therapy services, or I have and can provide proof of consent of the legal guardian):

Address: _____
City State Zip

Email Address (Please write clearly): _____

I wish to be contacted in the following manner (initial all that may apply):

Home Telephone: _____ Work Telephone: _____
 O.K. to leave a message with detailed information O.K. to leave a message with detailed information
 Leave message with call-back number only Leave message with call-back number only

I give legal permission to contact the following individuals at the following phone number(s) to discuss my treatment as it relates to the following (initial all that may apply): _____ All aspects of treatment, _____ Engagement in treatment, _____ Financial information only, _____ Attendance only, _____ Attendance and financial only

Name of person to contact: _____ Relationship: _____ Phone # _____

Name of person to contact: _____ Relationship: _____ Phone # _____

Signature of Responsible Party: _____ Date: _____ Expiration Date: _____

This release of information is good for up to one year and can be revoked at any time by signing. I no longer consent to release information to the individuals above (sign) _____ Date: _____

FINANCIAL RESPONSIBILITY (please fill out if other than primary client)

Name: _____
Last First Relationship

Address: _____
City State Zip

Phone: _____
Home Work Mobile

I accept full responsibility for all fees due to professional services. I realize that any third party billing is out of courtesy to me and does not transfer any financial responsibilities for unpaid services.

I understand that 24 hours notice is required to cancel or change an appointment, and that if 24 hours notice is not given, I am responsible to pay a cancellation charge of \$50.00.

Signature of Responsible Party: _____ Date: _____

IN CASE OF EMERGENCY

Nearest Relative

Name: _____
Last First Relationship

Phone: _____
Home Work Mobile

REASON FOR COUNSELING

WHAT DO YOU HOPE TO ACHIEVE FROM COUNSELING

How did you hear about us? _____

If on line what website or search words did you use? _____

Were you referred? Circle YES or NO If so, who referred you? _____

Have you ever received psychiatric or psychological help or counseling of any kind? If so, please explain: _____

MEDICATIONS

MEDICAL PROBLEMS

