

CLIENT REGISTRATION INFORMATION

Client Name: _____
Last First MI

DOB: _____ Marital Status: _____ Sex: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home _____ Work _____ Cell _____
Please circle the number(s), if any, where I may leave a message.

E Mail: _____ How should I contact you? _____

Employer: _____

Employer Address: _____

Student: Full-time _____ Part-time _____ School: _____

Permanent Address, if student: _____

City: _____ State: _____ Zip: _____

Telephone: Home _____

Person responsible for bill: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Please have responsibility party read and sign below.

STATEMENT OF RESPONSIBILITY: I have read the Informed Consent to Counseling, and I acknowledge that I have received the HIPAA Requirements described in the Informed Consent form. I understand that I am financially responsible for all charges made to me by my counselor. I understand that I will be charged for any appointments not canceled at least 24 hours in advance.

Signature: _____ **Today's date:** _____
Client or Parent/Guardian