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Self	**Spouse**
Name: ______________________________	Name: ______________________________
Address: ____________________________	Address: ____________________________
___________________________________	___________________________________
Home Phone: ____________________ Cell Phone: ______________________	Home Phone: ____________________ Cell Phone: ______________________
Occupation: __________________________	Occupation: __________________________
Marital Status: ________________________	Marital Status: ________________________

Name and ages of Children: ____

Age: _______Birth Date: _______________	Age: _______ Birth Date: _______________
Take medication(s)? : __________________	Take medication(s)? : __________________
Health problems? : _____________________	Health problems? : _____________________

Name(s) and number(s) of someone to contact in an emergency.

Self: May I leave a message on your home phone? ______Office phone? _________ Cell?:________

Spouse: May I leave a message on your home phone? ______Office phone? _________ Cell?:________

I understand that everything that takes place in my therapy session is confidential **unless** I pose a serious threat of harm to my self and/or others, or involved with child or elder abuse.

I understand that if I request for a "Super Bill" to be sent into my insurance for member reimbursement, payment of the agreed session fee is my responsibility.

FEE: $275.00 Signature ___________________________ DATE _________________