

Today's Date _____

About You:

Name _____ Age _____
 Occupation _____
 Address _____ | _____ | _____
Street City ZIP
 Phone(s) _____ | _____ | _____
Home Mobile Work
 Email _____ OK to send to this email address

About Your Spouse (or Partner):

Name _____ Age _____
 Occupation _____
 Address _____ | _____ | _____
Street City ZIP
 Phone(s) _____ | _____ | _____
Home Mobile Work
 Email _____ OK to send to this email address

Names & Ages of Children

Together with Spouse (or Partner)	Yours from prior relationship	Spouse's (or Partner's) from prior

Emergency Contact

Name _____ Relationship to you _____
 Phone(s) _____ | _____ | _____
Home Mobile Work

Medications

If any of the above persons take medications that affect mood or mental state, please provide:

Name _____ Medication _____ Physician _____
 Name _____ Medication _____ Physician _____

Payment and Agreement

Person(s) responsible for payment _____

Will you be submitting health insurance claims? Yes No Not Sure

I understand that I am financially responsible for the payment of all charges rendered to me or to any members of my family and that payment is expected at the time the service is rendered, regardless of any insurance coverage I may anticipate. I further understand that there will be a charge for appointments not cancelled 24 hours in advance unless the appointment time can be filled. I understand that, should legal action be necessary to collect any amounts owned by me, I will be responsible for any costs and attorney fees. I have read and understand the above statements and have received a copy of this agreement.

Signature

Date

Signature

Date