NEW CLIENT INFORMATION FORM

1. PATIENT INFORMATION

DATE: _____

Participant Name: _____
Gender: Male _____ Female_____ Neutral _____ Age _____ Date of Birth: _____

Street Address: _____
City _____ State _____ Zip_____

Best Phone # to contact you: _____ Alternate Phone #: _____
Email Address: _____

Spouse or Guardian Name(s): _____
Spouse or Guardian Phone number: _____
Spouse or Guardian Relationship: _____

How did you hear about us? _____

2. FINANCIAL RESPONSIBILITY

Financially Responsible Party: _____Date of Birth: _____

Address (If different from client): _____
Phone number: _____ Alternate Phone Number: _____

Employer: _____ Work Phone: _____

3. CONSENT TO TREAT

I understand this form represents permission for Michael S. Bouck, LCSW to provide the identified client(s) with mental health therapy and to seek payment for those services. I understand the benefits and risks of these services. I understand there are no guarantees with this type of care. I've had an opportunity to discuss any concerns or questions with my provider and I consent to participate.

_____ _____
Client (or Parent/Guardian) Signature Date

_____ _____
Client (or Parent/Guardian) Signature Date

_____ _____
Provider Signature Date