CLIENT INFORMATION

Scott Phillips, LMFT "Helping People & Relationships Thrive"
1007 Mopac Circle, Suite 201, Austin TX 78746 - (512) 850-5208

Client Name: _____

Date of birth: _____ Age: _____ Gender: ☐ M ☐ F

Street Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

I am informed that there are privacy risks associated with the following forms of communication and agree to receive messages at: (Check all those you choose to use)

☐ Phone 1: _____ Cell / Home / Work

☐ Phone 2: _____ Cell / Home / Work

☐ Email: _____

Person(s) giving consent for outpatient psychotherapy services for this minor:

Name(s): _____ Relationship: _____

How did you hear of me? _____

May I thank this person for your referral? ☐ Yes ☐ No

Person(s) to Contact in Case of Emergency:

Name(s): _____ Relationship: _____

Phone 1: _____ Cell / Home / Work

Phone 2: _____ Cell / Home / Work

☐ I have received and read the "*Notice of Privacy Practices*" for Scott Phillips, LMFT.

☐ I have received and read the "*Client Agreement*" for Scott Phillips, LMFT.

Your signature below indicates that you have read both the "*Notice of Privacy Practices"* and the *"Client Agreement"* understand the policies, rights, and responsibilities outlined and agree to abide by their terms during our professional relationship.

Signature: _____ Date: _____

Printed Name: _____