CLIENT INFORMATION FORM

Scott Phillips, LMFT "Helping People & Relationships Thrive"
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Client Name:

Street Address:

City, State, ZIP:

Date of birth:

Employer / Occupation:

Person(s) giving consent for outpatient psychotherapy services for client who is a minor:

Name(s): Relationship:

I am informed that there are privacy risks associated with the following forms of communication and agree to receive messages at the following:

Phone 1:

Phone 2:

Email:

Person(s) to Contact in Case of Emergency: (including Telehealth Sessions)

Name(s) / Relationship:

Phone 1:

Phone 2:

Name of Local Emergency Services:

Phone:

Address:

Name of Local Crisis Hotline / Center:

Phone:

Address:

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

Signature: Date:

Printed Name: