Christian Child Therapy

CLIENT INFORMATION SHEET

Personal information		
Name:		
Street: City: State: Zip:		
Home #:	Cell #	Work #:
May your therapist leave a message at home? Yes ◯ No ◯ at work? Yes ◯ No ◯ on **cell**? Yes ◯ No ◯ May your therapist leave a **TEXT** message on your cell? Yes ◯ No ◯ May your therapist leave an ***email*** Yes ◯ No ◯ Your e-mail address:		
Religion: Education: How do you identify by gender?		
Age: Birth date: Sex: ◯ F ◯ M Race:		
Reason for seeking Therapy:		
Emergency contact: Phone #: Relationship:		
Occupational status		
Employer name: Occupation:		
Street address:		
City: State:_____Zip: _____ Years with this employer ____		
Marital Status		
☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed If married, Spouse Cell:		
If your therapist provides psychotherapy with your spouse, should your therapist use his/her own judgment in sharing information or observations from your therapy? Yes ◯ No ◯		

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For our records
Who referred you to us?

This is a confidential record of your personal information. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in your **Client Policies**.

I consent to counseling, psychotherapy and diagnostic testing as prescribed by my therapist.
I agree to be responsible for the co-pay per session as agreed by my insurance agency. I further understand that I am responsible for payment for each session that is not covered by my Insurance agency as listed as a "deductible" or otherwise not covered by my insurance.
I understand that I am responsible for pay the full fee for any appointment that I do not keep or I cancel less than 24 hours in advance (except for an emergency).
I also understand if my therapist attends court on my behalf, I am responsible for the fees. I

Understand that any time set aside in preparation for a subpoenaed court appearance, Preparing of testimony or reports to the court, travel, time, waiting, depositions, etc. will be Billed at an hourly rate of $100 per hour.

NOTICE TO CLIENTS
The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

By entering your typed name, you agree that the provided "e-signature" will be the electronic representation of your signature for the purposes of this document. You further understand your electronic signature will have the same legally binding effect assigning your signature using pen and paper. Submission of this signed and dated document shall evidence acceptance of your acknowledgement and consent.

_____ _____

Client Signature Date

_____ _____

Deborah A. Lowe, PsyD, LMFT Date