PERSONAL INFORMATION/CONSENT FORM

THERAPIST: Erick K. French, MSW, LCSW DATE_____

PATIENT'S NAME_____

Date of Birth_____

Address_____
(Street) (City) (State) (Zip)

Home Phone_____ Work Phone_____

Cell Phone_____Email_____

Occupation_____ Alcohol, Cigarette and/or Drug Use_____

Medications_____ Medication Allergies_____

Previous Diagnosis_____

Sex: M / F Marital Status: Single / Married / Other Work Status: FT / PT / Other

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Complete the following if patient is under age 18.

Parent or Legal Guardian's Name_____

Date of Birth_____

Address_____
(Street) (City) (State) (Zip)

Home Phone_____ Work Phone_____

Cell Phone_____Email_____

Occupation_____ Alcohol, Cigarette and/or Drug Use_____

Medications_____

Sex: M / F Marital Status: Single / Married / Other Work Status: FT / PT / Other

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The client is only responsible for those insurance claims, such as co-pay, which are not covered. Payment is expected at time of service. The client is responsible for paying the full fee for appointments not cancelled 24 hours in advanced of the scheduled time. All information gathered as a result of treatment will be confidential.

I hereby consent to treatment and authorize the release of any medical or other information necessary to process claims for services. I also authorize payment of benefits to the Therapist for all services rendered.

X_____ X_____
Date Signature of Patient or Legal Guardian