Foundations
Counseling

Basic Information

Legal Name of Client: _____ Preferred Name: _____

Birthday: _____ Age: _____ Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Other

Mailing Address: _____

*May we send mail to this address? ☐ Yes ☐ No

Cell #: _____ *May we leave a detailed message at this number? ☐ Yes ☐ No

Work #: _____ *May we leave a detailed message at this number? ☐ Yes ☐ No

Email: _____

*May we email detailed account information message to this email? ☐ Yes ☐ No

Employment Status: ☐ Employed ☐ Student ☐ Other

*How would you like appointment reminders sent to you?

(Select One): ☐ Email ☐ Text ☐ Phone Call

*How did you hear about our office? (Ex: Friend, Doctor):

_____

Emergency Contact Information

Name: _____

Relation: _____

Phone #: _____

Please provide the following contact information to allow me to collaborate with your health care team, under the terms outlined on the "Patient Agreement and Consent to Treatment form:"

Primary Care Physician: _____ Phone #: _____

Psychiatrist: _____ Phone #: _____

Acknowledgment of Consent and Policy Statements

By initialing and signing this agreement, you are indicating that you have read completely all of the documents listed below and have had all of your questions answered. You agree to the provisions and policies freely and consent to treatment with Foundations Counseling. You also acknowledge that we reserve the right to update this information at any time and provide visible notification for your review.

1. Patient Agreement & Consent to Treatment — Client Initials: _____
2. Technology & Electronic Communication Policy — Client Initials: _____
3. Scheduling and Attendance Policy — Client Initials: _____
4. Billing and Insurance Policy — Client Initials: _____
5. HIPAA Notice of Privacy Practices — Client Initials: _____

Client/Legal Guardian Signature: _____ **Date:** _____

Printed Name: _____

Clinician Signature: _____