

CLIENT INFORMATION

Name: _____ Date of birth: _____

Phone: _____ Cell: _____ Work: _____

Address: _____ City: _____ Zip: _____

Employer: _____

Employer Address: _____

PERSON RESPONSIBLE FOR PAYMENT (if different from above):

Name: _____ Date of birth: _____

Phone: _____ Cell: _____ Work: _____

Address: _____ City: _____ Zip: _____

Employer: _____

Employer Address: _____

REFERRING PHYSICIAN:

Name: _____ Address: _____ Phone: _____

I hereby authorize () do not authorize () L.K. Ziegler, MA, LPC, LLC to release the following information to the above-named referring or primary physician: (Please initial)

Name of Counselor () Progress () Scheduled Appointments ()
Treatment Plan () Treatment Summary () Facility Admission or Discharge ()
Other (Specify):

Payment for all visits are due and payable at the time of the appointment.
You must cancel 24 hours in advance to avoid being charged for the appointment.
Insurance companies will not pay for missed appointments.

Client Signature: _____ Date: _____