TEXAS Relationship Therapy

CLIENT INFORMATION FORM *All fields are required.*

Date:	**Which Therapist Will You Be Seeing?**	**Who Else Will Be in Session with You?**

PERSONAL INFORMATION

Name:	First:	M.I.	Last:	Preferred:

Age:	Birth date:	Identify as: Male or Female or Other:

Address:	City:	State:	Zip:

Preferred Phone:	Email:

Relationship Status: Single / Engaged / Married / Divorced / Widowed	
Occupation:	Employer:

Religious Affiliation: None / Protestant / Catholic / Jewish / Mormon / Orthodox / Muslim / Hindu / Buddhist / Atheist / Agnostic / Other:

Race: Black/African-American / Asian / Hispanic/Latino / Multi-racial / American Indian/Alaska Native / Pacific Islander/Hawaii Native / White/Caucasian / Other:

Current Medical Diagnoses:

Prescribed and OTC Medication:

Any self-declared chronic illness and/or disabilities?

Are you currently seeing any other counseling professional? If yes, name:

ADDITIONAL INFORMATION

How did you hear about us? (Please be specific: Search Engine, Search Terms, Friend, Magazine, TV show, Event, Radio Commercial, etc.)	

If referral is a physician:	Name:	Phone:	Okay to Say Thanks for referring You? Yes or No

Person Responsible for payment:		Phone No.:

Email Address of person responsible for payment (if not SELF):	Note: We will need to contact this person to confirm payment responsibility (INITIAL HERE:_____)

IN CASE OF EMERGENCY

Name:	Relationship to Client:	Phone:
Primary Care Physician:	Type of Physician:	Phone:

PAYMENT INFORMATION (REQUIRED)

I understand that I am financially responsible for any balance. I understand that my provider today is out-of-network and I must pay my fee in full by cash, check, or credit card. Upon request, I will be given a receipt by my therapist so that I may file with my insurance company for reimbursement.
By providing my credit card to Intake Staff, I authorize my credit card to be charged to process payment for my session(s) at the time of service or in case of a late cancellation/no show.
Please let your therapist know if you would like to split the payment of joint sessions with your partner.

Signature:	***Note: You will be charged for sessions after your initial session not cancelled with 24 hours' notice.***

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law)